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ABSTRACT

This monograph describes a project developed at Children's Hospital of Boston as an innovative, exemplary program of training, research, and services for the treatment of family violence in a pediatric hospital, with a particular focus on child abuse and neglect. Chapter 1 explains why it is important to study the area of family violence, presenting the view that violence is a family problem and describing several forms of child abuse, including physical abuse, neglect, and sexual abuse. Chapter 2 discusses conceptual and procedural challenges facing family violence service programs. Chapter 3 provides an overview of what is known about family violence, looking at the incidence and causes of family violence, research on pediatric social illness and sexual victimization, issues of defining and labeling, effects of maltreatment and sexual abuse on children, spouse abuse, effective interventions, limitations to research evidence, and service needs. Chapter 4 presents the Children's Hospital Program on Family Violence, describing the Trauma X team, the Family Development Study, the Family Advocacy Program, the Family Development Clinic, the development of a clinical training program, and inservice training. Chapter 5 looks at the model hospital-based training program on family violence, discussing the family violence seminar, the journal group, fellowship program, how to bridge research and practice, and issues in clinical training. Chapter 6 examines professional roles in the service and training program in family violence, and chapter 7 provides conclusions and recommendations. References are included. (NB)

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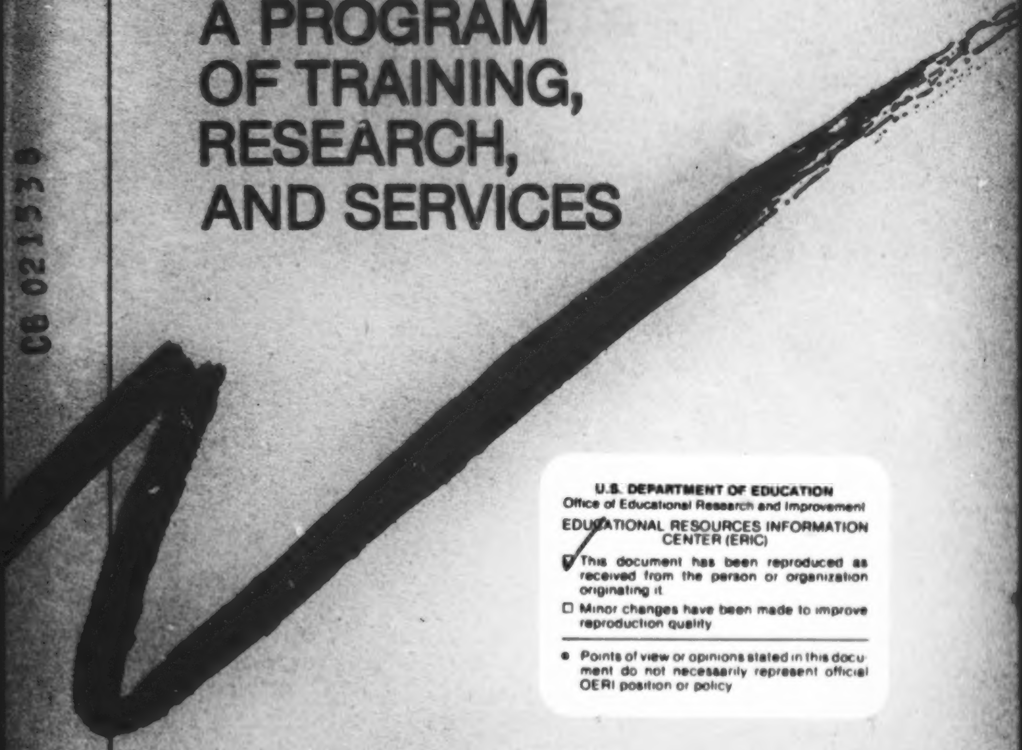
National Institute of Mental Health

TREATING FAMILY VIOLENCE IN A PEDIATRIC HOSPITAL:

A PROGRAM OF TRAINING, RESEARCH, AND SERVICES



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TREATING FAMILY VIOLENCE IN A PEDIATRIC HOSPITAL:

A PROGRAM OF TRAINING, RESEARCH, AND SERVICES

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Foreword

This monograph describes an innovative, exemplary program of training, research, and services for the treatment of family violence in a pediatric hospital, with a particular focus on child abuse and neglect. The report highlights critical conceptual and procedural issues, the limits of current clinical knowledge and related service needs, and various gaps between research and practice that must be addressed in the development and implementation of more effective hospital-based programs for the treatment of family violence. This monograph is based on the experience of an interdisciplinary training program, funded in 1979 by the National Institute of Mental Health's Antisocial and Violent Behavior Branch, in which postdoctoral clinicians and academic researchers were trained for interdisciplinary collaborative studies relevant to the understanding and treatment of family violence.

Among the conceptual and clinical innovations embodied in the program run by Dr. Eli Newberger and his colleagues is the view that child maltreatment is a family problem and that a whole host of childhood medical problems can most usefully be conceptualized as "pediatric social illnesses" with familial, child developmental, and environmental antecedents. This view helps to shift clinical and treatment attention away from an exclusive reliance on acts and perpetrators, or symptoms and sanctions, to a more productive concern with familial and environmental causes and various points of intervention. Moreover, this program has long recognized the critical importance of training—beyond the bounds of particular specialties and disciplines—as a means of bridging the gap between empirical research and clinical practice, and providing better informed and more effective services to victims of intrafamilial violence.

The setting for the training program, Children's Hospital in Boston, reflects the reality that medical services are frequently the first (and sometimes only) point of entry into the human services system for victims of family violence. Centering the program at this regional pediatric facility, which has been a major teaching resource for the Harvard Medical School, also reflects the belief that pediatric hospitals have important roles and responsibilities in the family violence area, including the training of clinical and research professionals as well as the development of specialized services. In the training program, clinicians have learned to design and conduct—by themselves and in collaboration with trained scientists—high-quality research on questions of importance to their own clinical work and interests; similarly, behavioral and social scientists have been oriented to the importance and necessity of conducting research in those clinical settings where their findings can more readily be translated into practice.

We are pleased to make this monograph available to a wide audience of program directors, clinical practitioners, and clinical researchers and trainers in children's and general hospital settings; to clinical and research faculty in graduate schools of nursing, psychiatry, psychology, and social work in connection with training in the area of family violence; to mental health, social service, and protective care personnel at State and local levels; and to academic researchers in the behavioral and social sciences. We hope that the monograph will be useful for the development of improved services for the prevention and treatment of family violence.

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Preface

Dealing with family violence is no easy task. Within medical settings, the urgent need for acute medical care can make it particularly difficult to deal with the social and environmental contexts within which family violence is embedded. Moreover, medical personnel often have little training in handling ambiguously defined problems for which there are no simple procedures or drugs.

Several years of experience at Children's Hospital Medical Center in Boston have made it clear that a training program in family violence can do a good deal to counteract the frustration and pain that come with the attempt to address problems of family violence in a hospital setting. This experience is shared in this monograph, which is intended to inform, educate, and encourage hospitals, related health delivery systems, and mental health and social service agencies to develop and/or strengthen their own programs and activities in the area of family violence. The monograph should also be of interest to State and local social service, child protection, and related agencies, as well as graduate training programs in various mental health disciplines.

A paradox arises in the treatment of family violence in medical settings. For the most part, hospital personnel are oriented to the treatment of symptoms; unfortunately, if the underlying causes of family violence are not addressed, the symptoms recur. Hospital staff typically do not have the wherewithal to deal with such issues as unemployment, or the subcultural or societal values that facilitate acceptance and promotion of violence as legitimate ways of solving human conflicts. Moreover, the family violence field has a way of wearing down even the most optimistic and energetic professionals. An effective training program can provide a continuing source of intellectual stimulation and valuable experience that can offset some of the sadness and futility that seem inevitable when trying to help victims overcome the sometimes insuperable obstacles of the medical, social work, and legal bureaucracies.

With the development of a training program at Children's Hospital, work with cases of family violence became easier. Members of the hospital staff were increasingly congenial to the Trauma X (child abuse) treatment team. Colleagues also become more responsive to issues raised in consultations about particular cases and in teaching conferences about family violence. By providing tools for improved understanding and service interventions in regard to family violence, the program led to more active and sensitive involvement on the part of individual hospital personnel and diverse specialty units.

Our experience also showed that even a rather small initial core of dedicated medical practitioners can establish extremely productive cooperative relationships with social service personnel and behavioral scientists. Armed with persistence and intellectual excitement, such practitioners can open the doors of the teaching conferences, which are normally restricted to members of the hospital's medical staff. Teaching conferences and case discussions can be used to address the larger contextual issues of family violence. With such exposure, professionals can gain a clearer sense of what can be done when, for example, they are facing problems related to the status of women in marital conflicts or addressing alcoholism and other substance abuses. With consideration of these broader issues, medical practice pertaining to family violence can be improved.

In addition, inservice education can stimulate all participants with new knowledge, varied clinical and research approaches, and the complementary perspectives of people from different disciplines. A rich process of exchange can be set up. Hospital staff can learn from behavioral scientists and social service personnel. These professionals in turn can broaden and deepen their understanding of human behavior and of clinical work within a medical setting.

We acknowledge with deep appreciation the contributions of our colleagues whose support enables us to continue our work in this field: Helen Berkley, William Bithoney, Lisette Blondet, Roy Bowles, Jessica Daniel,Barbara Danzell, Howard Dubowitz, Debby Fenn, Amy Garber, Richard Gelles, Robert Hampton, Drew Hopping, Daniel Kessler, Sylvia Krakow, Joanne Michalek, Carolyn Newberger, Tim Schuettge, Stephen Shirk, Betty Singer, and Pamela Whitney. We also extend our thanks to the members of the staff of the Antisocial and Violent Behavior Branch at the National Institute of Mental Health, and of the National Center on Child Abuse and Neglect, whose guidance

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Chapter 1

Why Family Violence Is an Important Area

> In the course of time Cain brought to the Lord an offering of fruit of the ground, and Abel brought of the firstlings of his flock and of their fat portions. And the Lord had regard for Abel and his offering, but for Cain and his offering he had no regard. So Cain was very angry and his countenance fell.
>
> Cain said to Abel his brother, "Let us go out to the field." And when they were in the field, Cain rose up against his brother and killed him.

Cain and Abel, those well-known Biblical figures, were brothers; the violence between them represents just one of the forms that family violence can take. Brother can fight with brother, sister with sister, spouse with spouse, parent with child, child with parent—and conflicts between any pair of family members are likely to be embedded in more widespread patterns of violence and neglect.

The type of family violence usually seen within a pediatric hospital or clinic is what is commonly called child abuse. Moreover, much of the literature in the field of family violence focuses on the maltreatment of children. However, considerable evidence shows that focusing on child abuse to the neglect of the more general problems of family violence leads not only to oversimplified conceptions of the issue but also to short-sighted clinical solutions.

Sometimes when children are brought to medical settings with injuries that clearly were inflicted, blame is placed on a sibling. Trying to determine whether the sibling really inflicted the injury may distract clinicians and other involved professionals from the larger task of determining what in the family circumstances explains why violence is occurring, and just how generalized the violence is. Consider three cases seen in just 1 day at Children's Hospital.

Nancy, a 1½-year old girl, was admitted through the emergency room because of burns to the head and fingers. Examination revealed healing burns on one hand and old scratches and bruises scattered over her body. Her "social" admission was linked to the various symptoms of abuse. After a 51-A (child abuse report) was filed by the hospital, it was learned that her 7-year-old brother had been in foster care until about 6 months earlier, that the family was an open Department of Social Services case, and that the brother's stay in foster care stemmed from an earlier care-and-protection decision based on evidence that he had been burned and neglected. The brother was considered to be a seriously disturbed firesetter, and apparently he had been alone with Nancy when she received the head and finger burns. Clearly, an effort to determine whether the brother had inflicted Nancy's latest burns does little to address the multiple problems facing these children, and indeed the entire family.

Admitted on the same day was *Nora*, an 8-year-old girl allegedly raped by her 16-year-old brother. Conversations with the mother revealed that she had been concerned about this boy's sexual interests for about 2 years. Indeed, she and the boy's older sister had visited a psychiatrist to express their concerns—and had been told that his behavior was just a normal part of adolescence.

While the rape of an 8-year-old child might seem to some family violence experts like clear evidence of parental neglect or putting a child at risk, the parents in this case seemed appropriately concerned and anxious for help. With the support of a social worker, the mother called all the neighborhood families for whom the boy babysat and said that he would be unable to work for them anymore because he was "having problems." A psychiatrist specializing in sexual abuse took the boy into therapy and arrangements were made for psychiatric help for the raped daughter. Social services input, as needed, was also made available to the parents.

Malcolm, a 9-year-old boy, was admitted with amputation of a finger tip while away overnight at camp. There was no question of an inflicted injury in Malcolm's case; indeed, superficially the injury seemed very much to be an accident.

However, Malcolm's family was known at Children's Hospital because a younger sister had been admitted several months earlier with a diagnosis of failure-to-thrive.

An investigation into the family circumstances revealed that Malcolm had been placed in the summer camp by a social service agency that wanted to give him a good summer experience and to get him away from parents who were seen as neglectful and as failing to supervise him. While at Children's Hospital, Malcolm was seen by a psychiatrist who characterized him as needy, hostile, and having difficulty with relationships. Malcolm's "accident" appeared to be symptomatic of his failure to protect himself in a family of five children where most of the parenting was done by Malcolm's twin sister. Calling Malcolm's injury an "accident" while labeling some other child's injury "abuse," though technically correct, would mean ignoring the whole host of common factors in the two situations, and perhaps in both cases failing to identify the kinds of family interventions that might help safeguard the futures of these children and their siblings.

These brief vignettes illustrate several points: (a) things are not always what they seem; (b) relying on a determination of parent culpability as a way of neatly classifying injuries as "inflicted" or "accidental" may not be the most useful approach to the circumstances surrounding the injury; and (c) a focus on the injury *per se* rather than the circumstances in which the injury is embedded may result in failure to address those underlying problems—so that nothing is done to alleviate the probability of repeated medical problems. Newberger et al. (1977) pointed out that a number of childhood medical problems ("pediatric social illnesses") have a "social" (generally family) component in their etiology. Included within this category—along with accidents and failure to thrive—are child abuse and neglect. However, differentiating among the various pediatric social illness diagnoses may not be as important as recognizing that familial/environmental issues may need to be addressed in all cases. Careful evaluation often uncovers a broader constellation of violence and/or neglect, or of circumstances putting other family members, as well as the pediatric patient, at risk.

VIOLENCE AS A FAMILY PROBLEM

Conceptualizing domestic violence as a family problem rather than focusing more narrowly on child maltreatment has many implications for both researchers and practitioners. Behavioral scientists seeking to understand the etiology of child abuse need a systemic perspective—consideration of the two parents and their relationship, of all family members in relation to each other, and of the family in relation to neighborhood and broader social institutions. Similarly, if one is concerned with the effects of the family environment on the child, including the possibility that observing violence will affect the child's behavior, then a systemic conception of the family is indeed essential. (The possibility that children can be victimized by observing rather than directly experiencing violence must be considered.)

FORMS OF CHILD ABUSE

Because the abused or neglected child is often the "identified victim" who brings a multitude of family problems to light, the rest of this chapter focuses on the types of cases most likely to be seen in pediatric practice. As covered by the mandatory reporting laws, "child abuse" refers to physical and emotional abuse and neglect, medical and educational neglect, and most recently, sexual abuse and exploitation. In the course of evaluating and treating a range of problems—including accidents, ingestions, failure-to-thrive, and any number of medical conditions, medical and social service personnel may discover evidence of one or several of these forms of abuse. Moreover, other members of the family, including parents and grandparents, may be victims as well as victimizers in a cycle of violence and neglect. In each of the following examples of the major types of child abuse cases seen at Children's Hospital, it should be clear that focusing only on the symptoms of the child patient means neglecting a whole host of related problems.

PHYSICAL ABUSE

Greg was a 3-year-old admitted with a spiral fracture (i.e., a fracture giving evidence of twisting) of the right leg. He also had a healing fracture of the right arm (that is, a fracture incurred earlier), and multiple bruises on the face, head, arms, chest, back, buttocks, and ears. Examination also revealed an old fracture of the left seventh rib.

Greg was the older of two children living with a divorced mother and her boyfriend. At the time of admission, the mother reported that Greg had fallen out of the car while it was moving and that she had fallen on top of him (while the boyfriend was driving the car). A friend of the mother's who called the hospital and asked to speak to a social worker, reported that the boyfriend was violent, abused the children, and had been indicted for assault on a man whom he assumed had made a pass at the children's mother. When questioned by a social worker, the mother admitted that the boyfriend had abused both children severely, but refused to alter her account of Greg's injuries.

Neither mother nor boyfriend went to see the child, who appeared very withdrawn, after his admission. Faced with strong evidence of physical abuse, the hospital filed a 51-A and a care-and-protection petition, and both children were placed in foster care.

Greg's case was somewhat atypical in that the evidence of abuse was clearcut and witnesses to incidents of abuse were available and willing to testify. Despite these circumstances, Greg had been admitted by referral from a small community hospital where physicians were convinced of abuse, but did not want the responsibility of filing a child abuse report. Indeed, the process of entering the legal/judicial system with cases of abuse is not typically relished by the individuals and agencies involved.

CHILD NEGLECT

Neglect of children can be broadly defined as failure to provide for or meet their emotional and developmental needs, including the need for adequate nutrition, clothing, shelter and safety, intellectual stimulation and education, and health and dental care. The problem is more omission of care than commission of injury. When such a broad definition is adopted, all parents my appear at times to fall short of meeting a child's many needs. However, the question of neglect arises when lack of parental care appears to be jeopardizing physical or emotional well-being or interfering with development.

Child neglect seems to be more pervasive than the physical abuse of children. When harm to a child is severe enough to require hospitalization or medical attention, it is one and a half times more likely to be due to neglect than to physical abuse

(American Humane Association 1981). Data from the National Reporting Study indicated that 63 percent of all reported cases of child maltreatment involve "deprivation of necessities," while emotional maltreatment accounts for 14 percent of all reported cases of child abuse.

Neglect is often associated with abuse, and medical practitioners may see expressions of both problems in the same children. Martin (1980) noted that children who have been physically injured by their caretakers are also more likely to have received inadequate medical care, including lack of immunizations; moreover, their illnesses, such as ear infections, often go untreated. He also reported a higher incidence of undernourishment and anemia among physically abused children. Similarly, Newberger et al. (1977) reported that victims of physical abuse are more likely to be underweight for their age and are less healthy than children with other diagnoses.

Melissa was a 1-year-old admitted with low weight gain and failure to thrive. She had gained only 3 pounds since birth. Both parents alleged that Melissa had not gained weight because she was difficult to feed; however, they also admitted to giving her frequent laxatives although they had been told by clinic staff not to do so. In the hospital Melissa appeared ravenous. The child's medical record revealed that the mother had a history of resisting and breaking medical appointments for the child. Also of concern was Melissa's 3-year-old brother, who had also been seen for failure to thrive and who showed no normal language development.

When the hospital's Trauma X (child abuse) team evaluated Melissa, they concluded that the only apparent basis for the failure to thrive was parental neglect and failure to feed her; there was simply no evidence of any organic condition. On the basis of this diagnosis, a care-and-protection petition was filed and the court awarded full temporary custody to the State Department of Social Services.

While this action was seen as fully appropriate by the Trauma X team, several nurses believed that the parents behaved in a warm and caring manner with their child, and that the legal action was inappropriate. Such disagreements are not uncommon among staff members who are unequally trained in issues of child maltreatment. Indeed, one of the difficulties associated with addressing issues of family violence and neglect is such disagreement among observers.

SEXUAL ABUSE

The sexual abuse of children by adults has been labeled the "last frontier" in child maltreatment. It is the form of maltreatment most recently discovered by the pediatric community and society at large—although, as was the case with physical abuse and neglect, historians have noted its occurrence for centuries (DeMause 1974). Sociologist David Finkelhor (1979b) noted that the "discovery" of this social problem was facilitated by the women's movement, which brought the problem of rape and sexual abuse of women to public consciousness, leading in turn to awareness of the sexual victimization of children.

In the area of sexual abuse, as in other areas of family violence, it is important to have clear definitions. While some people (for example, members of the Man-Boy Love Association) argue that sexual relations between adults and children can be "good" for, and enjoyed by, children, any sexual interaction with a child that is undertaken for the sexual gratification of the adult should be considered exploitative and abusive. A judgment of sexual abuse is also appropriate when (a) children are exposed to or involved in sexual activities inappropriate for their developmental level, (b) children are exposed to or involved in sexual activities inappropriate for their roles in the family, and (c) children are unable to give informed consent because of age or power differences in the relationship.

Estimates of the incidence of sexual abuse vary. Gagnon's reanalysis of Kinsey's data on 1,200 adult women indicated that 28 percent had at least one sexual experience with an adult prior to the age of 13 (Gagnon 1965). (Gagnon's definition of sexual experience includes exhibitionism as well as physical contact, which is consistent with the criteria just listed.) Applying this rate to the population of girls under 13 leads to an estimated incidence of 500,000 cases of sexual abuse per year. According to data from the American Humane Association, in 9,000 cases of sex crimes against children, 75 percent of the perpetrators were adults who were familiar to the child. In a recent study of almost 800 college students, 19 percent of the women and 8.6 percent of the men reported sexually victimizing experiences as children (Finkelhor 1979a). The most common sexual experience was genital fondling. For women, half of the perpetrators were family members; for men, family members constituted 17 percent of the perpetrators.

Reported victims of sexual abuse are primarily girls, who

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constitute 80 percent of the cases reported nationally (American Humane Association 1981). Surveys of adult women indicate that between 19 and 34 percent were sexually victimized during childhood (Gagnon 1965; Finkelhor 1979a). Finkelhor's data suggest that boys are victimized with greater frequency than had previously been thought. Based on several surveys of adult males, Finkelhor estimates that 2.5 to 5.0 percent of boys under the age of 13 are sexually victimized each year. This estimate extrapolates to an annual national incidence of 46,000 to 92,000 abused boys. The number of cases of sexual abuse that actually get reported each year is considerably lower than projections such as Finkelhor's, which are based on retrospective self-report data. In 1979, for example, 7,600 cases were reported (American Humane Association)—which is probably considerably fewer than the number of incidents that took place.

Sexual abuse may be underreported to a greater extent than any other form of child maltreatment for a number of reasons. First, the frequent absence of physical sequelae to the victim means that cases do not come to the attention of health professionals to the same extent as cases of physical abuse or neglect. Second, children are reluctant to report sexual experiences, particularly when the offender is a parent or other familiar adult. In Finkelhor's study (1979a), 63 percent of the female victims and 73 percent of the males had not told anyone about their experiences. Third, professionals themselves deny the problems. Rosenfeld (1979) has sensitively discussed the strong emotions engendered by sexual abuse cases in health and mental health professionals.

Katie, a 3½-year-old girl was admitted with vaginal bleeding after her father allegedly removed a squirt gun from her vagina. While damage to the vaginal area was extensive, the emergency room physician believed that the injuries were compatible with the father's story; nevertheless, a 51-A was filed by a social worker in the emergency room. The child's mother requested that the social worker evaluate the 8-year-old brother. Plans were also made for the Sexual Abuse team to evaluate all family members. Both parents vigorously denied any involvement by the father in the child's injuries, and despite strong suspicions on the part of the Sexual Abuse team the evidence of abuse was insufficient to justify removal of the child from the home.

Jenny was a 4-year-old admitted through the emergency room because of serious vaginal damage. Her distraught young mother reported that she had "given marching orders" to the man with whom she had been living. Before moving out, he had gotten her out of their apartment on some pretext, then raped Jenny (not his daughter). The man had since disappeared and the mother did not know where he had gone. While no one presumed the mother's complicity in the rape, some concern was expressed by members of the Trauma X and Sexual Abuse teams as to whether this mother could adequately protect her child.

CONCLUSIONS

Clearly, many children in our society are at risk of maltreatment through physical abuse, neglect, and/or sexual abuse. Oftentimes, but not always, the effects of such maltreatment bring these children to the attention of medical and social service personnel. Sometimes the symptoms of the maltreatment can readily be identified for what they are. More often, perhaps, the symptoms are ambiguous, and professionals may disagree as to whether maltreatment has taken place. Even when a child is clearly at risk in a particular family environment, the appropriate action is not always obvious. Evidence that is sufficient to convince hospital personnel that maltreatment has taken place is not necessarily sufficient for the judicial system.

Child maltreatment, like other forms of family violence, has been recognized as a social as well as a medical problem. As such, it has received attention from social and behavioral scientists desiring to understand the problem, as well as from clinicians faced with making decisions about how to deal with its effects. In the chapters that follow, we consider both researchers' findings about family violence and the barriers to using research knowledge in hospital settings.

Chapter 2

Conceptual and Procedural Challenges Facing Family Violence Service Programs

Michelle, a 1-year-old girl, was brought by her parents to the emergency room because of an ear infection and a suspected seizure. *Derek*, 10-year-old son of divorced parents, was referred to the Hospital's Family Development Clinic by the attorney for his mother, the noncustodial parent, who was seeking to regain custody from an allegedly abusive father. Are Michelle and Derek the victims of child maltreatment? Who should make this judgment? When is the evidence of abuse sufficient to justify the filing of a child abuse report? Who decides that the evidence is sufficient? What kind of evidence is appropriate? Is it enough to have a lack of fit between the nature of the child's injuries or overall condition and the parent's explanation of the problem? Is it useful or relevant to inquire about the family's general living situation, current concerns, and so forth? And again, who decides?

In this chapter, we present the argument that in each of these cases family problems were being expressed as symptoms in the children who were brought to the hospital for care. In each case, judgments about whether maltreatment had taken place were influenced by conceptions of the nature of child maltreatment and its etiology. Conceptions of child abuse that are incomplete or in some ways incorrect can lead to incorrect diagnoses—assuming child abuse has taken place when it has not, or missing cases of child abuse when they appear. Indeed, viewing child abuse as a simple matter of gruesome injuries inflicted on a helpless child by a "sick" parent, while popular, neglects much of what we have learned about family violence. Before presenting the cases of Michelle and Derek in more detail, we discuss major views on child abuse and family violence that influence the handling of such cases.

CONCEPTIONS OF THE PROBLEM

Efforts to identify the characteristics of "child batterers" began with the identification of "battered" children by Kempe and his colleagues (Kempe et al. 1962). In this approach, children are seen as victims and parents as victimizers. From this perspective, it is appropriate to try to define the characteristics of "child abusers" (e.g., Fischhoff et al. 1971) and to treat the child abuse by excising the malignant agent—e.g., by putting the parent(s) in jail or in other ways making it impossible for them to inflict further injury on the child.

Since the publication of the Kempe paper, a number of efforts have been made to develop screening inventories (e.g., Milner and Ayoub 1979; Paulson et al. 1975) for identifying potential or actual child abusers. However, while some circumstances in people's lives may increase the likelihood of child maltreatment, there is strong evidence that only a few abusing parents show severe neurotic or psychotic characteristics; indeed, child abuse may be associated with several different parental personality types (Smith et al. 1975).

The assumption that child abuse is the product of parental psychopathology is quite consistent with what Sarason and Doris (1968) and other social scientists have called the *medical model*. From this perspective, the etiology of a problem like child abuse is mental illness, and the focus of intervention efforts is on treating the sick parent—for example, through psychotherapy. In the medical model, we would expect to see medical practitioners addressing the medical problems of the child, and social workers and psychiatrists dealing with the parent's presumed psychopathology—unless, of course, the judicial system intervenes. While this approach may seem to work in some medical institutions, it is not responsive to the complexity of the problem of family violence and thus leaves many of the contributing problems unaddressed.

Family violence, generally, as well as child abuse more specifically, is often conceptualized by social scientists as the product of poverty and/or stress—and here the concerns are quite different from those of the medical model. From the perspective of this *stress model*, all individuals caught up in the cycle of family violence are victims, even if only the child bears the scars of inflicted injury or neglect. Social scientists subscribing to this approach see little sense in trying to identify the personality characteristics of child abusers; they believe, instead, that almost any individual can become violent toward other family members if placed under enough stress. The solution to family violence, then, is to address the problems of poverty, unemployment, chronic illness, and so forth, that give rise to the violence. While substantial empirical evidence may support a link between stress and violence, this link may seem irrelevant to medical practitioners who see the correction of social ills as legitimately outside their area of concern and expertise. Familiarity with the stress model may nevertheless influence the interpretations brought to a particular case of child maltreatment by clinicians—particularly social workers who see such problems as falling within their domain.

Substantial evidence, some of which is reviewed in chapter 3, shows that neither the parental psychopathology nor the stress/poverty model is sufficient to account for the problem of family violence. Characteristics of the parent, characteristics of the child, characteristics of the situation (e.g., level and type of stress) all appear to contribute to the likelihood that various forms of family violence may take place. Indeed, a ***systemic model*** of family violence, in which the potential role of a range of interrelated factors can be considered, appears to be a much more valid and useful approach to the problem. Such a model was developed by Newberger and Bittner (Bittner and Newberger 1981) and can be found in chapter 3, along with a review of the research supporting different elements within the model. For further discussion of the limitations of unitary models of child abuse and the advantages of a systemic approach to family violence, see Newberger and Newberger (1982).

CASE VIGNETTES

Let's return to the cases of Michelle and Derek and see how conceptions of family violence and issues of training and turf affect the response of hospital personnel to children at risk.

Michelle

One-year-old Michelle was brought to the emergency room by her parents. According to the history taken from the parents, who were young and described by the social worker as "appropriately concerned," Michelle had been healthy until 2 weeks before the visit when she developed an upper respiratory infection with congestion and nasal stuffiness. One day prior to her visit to the emergency room, the child was noted by her parents to be feverish and sweating. She vomited once. As was the usual practice, she had been taken by the mother into the parent's bed and nursed. At about 4:30 a.m., she woke crying and rolled off her parent's bed onto a carpeted floor, hitting her head. She cried immediately and her father put her back into her crib, at which time she appeared to be fine. Approximately ½ hour later, Michelle suddenly became tense all over her body and appeared not to be breathing. This episode lasted about 30 seconds, after which she was again responsive. The parents thought Michelle's eyes had deviated toward the left during the episode. The child was taken to the emergency room in a local hospital where an ear infection was diagnosed. She was sent home with a decongestant and an antibiotic, and the mother gave her one dose. She remained feverish, and at 11:00 a.m. the father heard a noise from the child's room. Michelle was found to be twitching all over for about 30 seconds, following which she was dazed for about 5 minutes and then returned to normal. At this point she was taken to the emergency room at Children's Hospital. While there, she had another seizure, which consisted of twitching of her left arm and deviation of her head to the left. In the emergency room the child was seen by a house officer and a pediatric neurologist. A social worker was called to speak with the parents, who were obviously upset.

The following information was obtained. Michelle had had an unremarkable birth history, and her development and growth appeared normal. She had fallen from her parent's bed on at least three or four occasions and had sustained a total of seven or eight falls since 4 months of age. At 4 months she had fallen out of her crib when her parents, not suspecting she could roll, had left the side rail down. The most recent fall had occurred when she fell down six stairs after she had opened a gate. Though she had hit her head on a number of these occasions, no medical attention had been sought because Michelle always looked well following the incident. The mother did, however, note these events carefully in her baby book.

On examination, Michelle looked healthy and was obviously well cared for. She had no bruises and no outward sign of trauma. The parents were supportive of each other. Michelle responded well to her parents and was easily comforted by them. The parents reported that the child was left-handed and had been so for months. A careful examination revealed that the child had a preferential reach with her left hand and that her right hand and foot were definitely smaller than the left.

A seizure in a child with a high fever is not uncommon. However, typically these seizures are generalized; they do not show laterality (the predominance of motor activity to one side or the other). This child's seizure was unusual because it showed evidence of a focus that was left-sided and not generalized. A discharge of activity in the right side of the brain was causing head, eye, and hand motor movements to the left. In addition, the lesion causing the activity appeared to be old, because of the early onset of "handedness" on the left; moreover, the difference in size between the left and right extremities indicated damage to the nervous system that was not of recent onset.

During their interview with the social worker, the parents were openly tearful and frightened. They appeared unconcerned about the number of falls the baby had sustained and openly shared information about the early stresses in their lives and the father's recent feelings of anxiety and depression. The father volunteered information that he previously had violent rages toward his wife, but that he had brought these under control when he started therapy—when Michelle was about 4 months of age (the time of her first fall).

How are we to understand a case like this? Is Michelle simply an unlucky, or perhaps "hyperactive" child, who has managed to fall prey to a number of chance "accidents" and a fever-inducing ear infection? Is the principal responsibility of hospital personnel to diagnose and treat the fever, or should they determine whether some form of parental failure to protect and nurture their child may have contributed to the child's history of repeated falls—a history that on the surface appeared unrelated to presenting symptoms of fever and seizure? What should be done if, as became evident in Michelle's case, the medical and social service staff cannot agree as to whether an injury or medical condition reflects troubled family dynamics or just a simple, ordinary, everyday type of accident.

To some extent, the referral of Michelle's case to the Trauma X consulting team was accidental. The social worker on duty when Michelle was brought to the emergency room was a member of the Trauma X team who was covering for another social worker. This Trauma X team worker became concerned over the social history of the family and the repeat accidents to which the child had been prone. The medical staff, particularly the young house officer on duty that night, interpreted the case as being exactly as presented—an ear infection that had led to a fever and minor seizures. This house officer saw no need for a

Trauma X consult. However, the social worker did see a need, and the process was set in motion.

What was the physician's perception of Michelle and her family? "Kids will be kids, all kids have accidents," he said. In Michelle's parents he saw two college graduates who owned a nice home in the suburbs and two cars, parents who kept careful records of their child's development, took her into their bed at night when she cried, and persistently sought medical help for her apparent seizures. How could abuse be suspected in such a nice middle-class family? In light of the literature on biases associated with the labeling process, it is not surprising that the physician refused to consider a diagnosis of maltreatment in this case.

On the other hand, what did the social worker see when she talked with the family? She saw a father who admitted that he had beaten his wife until recently—indeed, right up until the time the baby's falls had begun—and who reported that he had been in therapy 6 years because he had trouble controlling his "rage." The social worker also saw a mother who did not want her in-laws to know that she and her husband were at the hospital with the baby because she was afraid her mother-in-law "will have the baby taken away." Moreover, while the mother was pleased to share her diary of Michelle's infancy, it was noteworthy to the social worker that medical advice or treatment had never been sought in relation to the repeat accidents reported therein.

Which perception was correct—the physician's or the social worker's? What is the proper way to proceed when one professional is concerned about possible threats to a child's health and safety and another professional is not—especially when there is a major differential in power and authority? In this case the social worker sought the Trauma X consult. The physician, miffed that the social worker took action that he deemed inappropriate, banned that social worker from further contact with the family so that she could "upset them" no more!

Michelle's case illustrates well a number of the difficulties encountered within medical settings by professionals responsible for diagnosing and responding to child abuse. Physicians tend to view injuries and illnesses as medical problems in need of medical treatments. Social workers sometimes see injuries and illnesses as medical problems in need of medical treatments. Physicians have greater power and authority. Social workers generally are more subordinate, and they typically have less power and authority than members of the medical profession—especially in a hospital setting. Moreover, although roles are changing, physicians generally are men and social workers generally are women. Although gender, power, and prestige should be irrelevant to the goal of protecting children, in reality they can have a determinative effect. Who wins out when a young man with an M.D. after his name, freshly out of his internship though he may be, regards an experienced social worker as overly emotional, judgmental, and meddlesome? Whatever the merits of any particular case, it is unlikely to be the child who wins when titles rather than experience carry the day. Hospital legal staff are reluctant to pursue legal action on behalf of a child when their own professionals disagree about the merits of the case. Moreover, even when a case goes to court, the credentials of physicians may carry greater weight than the informed judgments of social workers—and, again, the child may be the loser under these circumstances.

What was particularly unfortunate in Michelle's case was that social science knowledge on family violence supported the social worker's interpretation. Nevertheless, this knowledge became irrelevant in the political arena of actual decisionmaking. Specifically, there was evidence of other forms of family violence (the father against the mother), a vulnerable parent who had a troubled relationship with his own mother and had been in therapy for years to help in controlling his rage, and considerable ongoing social stress, freely reported by both parents. All of these characteristics have been identified as contributing to the complex etiology of the multidimensional problem commonly known as child abuse.

Derek

The medical record for 10-year-old Derek, the child custody case, contained some important information about treatment administered to him at other hospitals on several occasions. For example, he had been x rayed and treated on one occasion for fractured ribs. Another time he was treated for head injuries. In all instances, his injuries were treated and he was released to his custodial parent, that is, his father—not an atypical outcome when a child is brought to a medical setting by a parent for treatment of injuries. Little had been done about the fact that the fractured ribs evidently had been caused by kicks to the chest inflicted by Derek's father; nor had action been taken when head injuries occurred because Derek's father threw him against a wall.

When Derek's mother found out about her exhusband's abuse of her son, she obtained a court order for temporary custody and an evaluation of Derek. In the ensuing Family Development Clinic evaluation, a chilling story of family violence emerged, a story that might never have been discovered in clinical settings focused only on healing injuries.

The oldest of nine children, Derek's mother married at age 17 to escape an unhappy home in which her own father frequently abused her mother. Soon pregnant, she became the victim of her husband's regular physical beatings. Derek was born prematurely, was "always sick," and himself became subject to his father's violent assaults. When he was 2, his mother left him in the care of her own mother. Distraught from her husband's abuse and his threats to shoot or stab her, Derek's mother admitted herself to a psychiatric hospital. Derek's father sought and won both a divorce and custody of his son from a judge who refused to talk to a boy who was unhappy and afraid about being placed with his father.

Derek's father continued beating him and a second wife, whom he married right after his divorce. The second wife also fled from the beatings, leaving her stepson behind. Ultimately, Derek's mother learned of the ongoing physical violence and sought custody of her son. On the basis of a thorough evaluation that confirmed the father's physical and emotional abuse of the child, the Family Development Clinic team recommended that the mother be given custody of her son and that Derek receive extensive psychological and educational services.

This story illustrates well the finding of social scientists (e.g., Straus et al. 1980) that child abuse frequently occurs in families where violence characterizes the spousal relationship. Derek's story is an emphatic reminder of the importance not only of looking beyond physical symptoms to their causes but also of avoiding a narrow conceptualization of child abuse. Often family violence envelops not just children but also adults, whose victimization may extend through many areas of their lives. Moreover, as a premature child with health problems, Derek can be seen as a good example of the vulnerable child described by researchers as susceptible to abuse from an early age. Finally, whatever his personal history or mental health status may have been, Derek's father, as a career military man, may have been particularly subjected to social-cultural pressures favoring strict discipline to enforce obedience.

As tragic as is the case of Derek and his mother, it has a relatively happy ending. Family Development Clinic personnel, as well as representatives of the judicial system, concurred that Derek should be placed in the custody of his mother and that the family should receive helping services. Such unanimity is by no means commonplace among the professionals who deal with family violence. Moreover, interventions on behalf of children and their families do not always serve those who are the most in need—for example, the mother whose inability to protect her child is linked to her own victimization.

RESPONDING TO FAMILY VIOLENCE CASES

As illustrated in these vignettes, cases of family violence create special problems in the medical settings where they are seen. Public recognition of child abuse as a medical-legal issue and mandatory reporting laws thrust new responsibilities on physicians and other clinical personnel who continue, generally, to be ill-prepared to handle them.

If institutions are to deal adequately with child abuse and other forms of family violence, a number of general goals deserve attention. One major goal should be to develop an interdisciplinary team. Members of the different professions typically have different perspectives, conceptions, terminology, and professional tools, and also different status in service-delivery and other settings. In light of the anger and frustration that can often be engendered when possible child maltreatment is being assessed, these differences can lead to and exacerbate problems in communication and in interpersonal relationships. Any institution undertaking an interdisciplinary team approach to family violence services must be prepared to cope with these problems. In later chapters we present a number of practical suggestions derived from our own experience for dealing with case management.

A second major goal should be the classic one of integrating research and practice, i.e., of finding ways of making extant behavioral and social science research available and usable to practitioners. Our message, reiterated several times in this monograph, is that the institutions should provide opportunities for researchers and practitioners to work together and to communicate their particular knowledge, skills, and viewpoints. Seminars, journal groups, colloquia, and case conferences can all be useful, especially if considerable care and flexibility are devoted to the process involved in developing and conducting these opportunities for interchange.

Establishing vehicles for communication between researchers and practitioners can be an important antidote to the affliction that often keeps these groups of professionals on two different wavelengths. A number of reasons account for the current gaps between social science and clinical knowledge, and opportunities to close these gaps are likely to benefit everybody. Consequently, it is useful for developers of training programs to understand the reasons for the gaps and to address these reasons in planning.

1. *Lack of communication among social scientists and clinicians*. Professionals tend to publish and to read within their own discipline. "Keeping up with the literature" can be an awesome task even within one's own discipline. Professional training programs tend to be unidisciplinary and draw heavily from a unidisciplinary literature. This narrow exposure is especially true within the field of medicine. Medical schools and residencies continue to emphasize biomedical course work and training. They typically exclude course work on psychology, the family, and social problems from the required curricula—even in regard to issues such as family violence, which have direct consequences for medical practice.

2. *A difference in the construction of knowledge and criteria for significance*. Even when communication does occur between clinicians and researchers, each group—at an interdisciplinary conference, for example—is likely to feel that the knowledge communicated by the other is irrelevant or invalid. This paradigm clash between social scientists and clinicians was well described by Gelles (1982). The researcher is often concerned with finding the smallest number of variables that explain differences between selected groups—for example, families in which violence occurs as compared with families in which violence appears to be absent. To the researcher, knowledge consists of accrued research findings that must meet standards of scientific validity such as adequate sampling size and techniques, use of control groups, and sufficient demonstration that the results are statistically significant—that is, they could not have occurred by chance.

The goal of the clinician, on the other hand, is to understand the individual case, to identify a particular problem, and to determine which of the clinical factors contributing to the problem are amenable to intervention. Knowledge consists of accrued experience with families or individuals, which might be categorized into types of families and problems, and knowledge of what does and does not work.

Factors of *clinical* significance might be different from factors of *research* significance. For example, while researchers might argue that parental alcoholism occurs in only a small percentage of family violence cases and is not a significant contributor to family violence *in general*, the clinician may be faced with individual families in which parental alcoholism appears to be a highly significant factor.

3. *Mutual skepticism*. Because of differences in training, in construction of knowledge, and in work roles, clinicians and researchers often feel mutual skepticism concerning each other's contributions to knowledge and to issues raised within the area of family violence. Researchers may assume that clinicians are not critical enough of the generalizations they make on the basis of their experience with cases and may dismiss the case study approach as nonscientific. Clinicians may assume that researchers are not aware of the real world and may dismiss research findings as too simplistic or irrelevant because they fail to capture the many variables operating in the lives of families or those that are amenable to change.

This lack of communication and mutual mistrust is a serious impediment to effective collaboration. Researchers may continue to design studies that fail to address issues of greatest significance for clinicians. Clinicians, meanwhile, may continue to generalize from their experience without the benefit of checking this very selected or biased experience against research findings with nonclinical samples and control groups.

CONCLUSIONS

In many hospitals, clinical practice with cases of family violence continues to be guided by conceptions focusing narrowly on child abuse. Emphasis remains largely on parental psychopathology as the cause of maltreatment, and on the parent as villain rather than another victim. Moreover, a symptom-oriented approach continues to guide medical practice, with insufficient attention given to the psychological and social dimensions of the case. The latter is particularly true for physicians, who, as a group, are in a position of authority for decisionmaking and case management in hospital practice. Hence, the biomedical approach may predominate amidst conflict with nurses and social workers more attuned to psychosocial issues.

The implications of these shortcomings for families and children are serious. Cases of violent, neglectful, or sexual maltreatment may be missed completely, or additional family victims may fail to be identified, and children and families may fail to receive the protection and services they need. Biases in recognition and reporting of cases according to race and socioeconomic status are also likely to occur. The myth that family violence is a problem only of poor people or of those very different from the professionals themselves continues to influence practice. Also, conflict among disciplines in case management, when cases are identified, may be the norm. An inadequate understanding of what causes family violence and a lack of agreement on how to manage such cases may result in inappropriate or insensitive intervention with families.

Now more than ever the need for training in this area is critical. Pressures on families, such as unemployment and financial stress, are increasing as helping resources are diminishing. Hospital emergency rooms increasingly become the gateways into the service system for families in trouble, as other doors have closed. Timely and sensitive intervention into the family processes behind the presenting symptoms may help prevent future hospital admissions and even save lives. It is essential that hospital professionals be knowledgeable about and prepared to deal with a number of components that can be adopted in other settings. Of particular importance is allowing some time away from a demanding schedule to review and reflect on one's work with families and the questions generated by colleagues and others offering different but useful perspectives. While one's own assumptions and biases may be challenged in an unsettling way, new information and perspectives can also lead to intellectual and professional growth. Before describing the major components of our own training program and making recommendations for training in other settings, we review, in chapter 3, research evidence concerning family violence that has implications for practitioners and that could be made available to practitioners through an interdisciplinary training program.

Chapter 3

What Is Known About Family Violence

The sanctity of the family has a long history. Traditionally, families have been regarded as a refuge for their members. Within families, individuals are presumed to care for and take care of each other. We now know that however rosy a picture may be painted of families in our folklore or in our popular media, family members can actually be a source of harm to each other.

This chapter provides a brief overview of what is known about family violence. We focus particularly on those products of family violence most likely to be seen in pediatric settings, i.e., children who have been physically or sexually abused and/or neglected. After summarizing what is known about the incidence of family violence, we review the research literature on the etiology of various forms of child maltreatment. The effects of violence and sexual abuse on children, the preferential labeling of certain groups of children as abused or neglected, and the effectiveness of different kinds of intervention in cases of family violence are also considered.

INCIDENCE OF FAMILY VIOLENCE

The true incidence of the various forms of family violence is difficult to determine. Statistics on the incidence of child abuse, for example, rely on figures from child protection agencies, which provide only the number of cases reported. While the nationwide incidence of reported child abuse cases is known to have increased by 71 percent between 1976 and 1979 to a total of 711,142 cases (American Humane Association 1981), experts agree that this increase reflects both greater public awareness of this social problem and increased agency accountability, rather than a rise in true incidence of child maltreatment.

A landmark study of the incidence of family violence was published in the book *Behind Closed Doors* by Straus, Gelles, and Steinmetz (1980). These sociologists surveyed a representative national sample of two-parent families with children between the ages of 3 and 17, concerning the incidence of violence among family members in their household. Administered in the context of an interview was the *Conflict Tactics Scale*, which presents a sequence of methods of conflict resolution, progressing from benign means to increasingly violent acts such as hitting, kicking, biting, or beating up, and ending with threats of or actual assault with a knife or gun. The results of the survey by Straus et al. (1980) are worth summarizing here.

Violence Toward Children

The prevalence of severe violence directed toward 3- to 17-year-old children was 3.8 percent in the survey year. One in every 1,000 children was threatened or assaulted with a knife or a gun. A projection of this ratio to the 46 million children aged 3 to 17 who lived with both parents during the survey year suggests that 1.5 to 2 million children per year are threatened or assaulted with lethal weapons; 46,000 of those children are actually subjected to use of a weapon. In addition, 8 out of 100 parents reported using one of these forms of violence against a child one or more times in the child's life. Children experiencing lesser forms of violence—kicks, bites, and punches—suffered such events an average of 8.6 times during the survey year. Beatings occurred an average of once every 2 months.

Violence was not confined to young children. When analyzed by age group, 82 percent of the 3- to 9-year-olds, 66 percent of the 10- to 14-year-olds, and 34 percent of the 15- to 17-year-olds, had been victims of some form of violence during the year. Although the figures are high enough to be very disconcerting, they may actually be an underestimate of violence directed toward children by their parents. First, the data are self-reported, and many respondents may have denied or played down the use of violence in their homes; second, omitted from the survey were two groups considered to be at risk for violence, i.e., children in single-parent households and children under 3 years of age.*

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* These two groups of children have now been included in an NIMH-funded replication and expansion of the 1976 survey, currently being conducted by Dr. Murray Straus and his colleagues at the University of New Hampshire. This "Resurvey of Physical Violence in American Families" will be completed in 1988.

Interspousal Violence

Straus et al. also reported that one out of every six respondents (16 percent) admitted some kind of physical violence at the hands of their spouse during the survey year. Over the course of marriage, the chance appeared to be greater than one in four (28 percent) that a couple would engage in an act of spousal violence. Projected to the 47 million marriages in the United States, the data indicate that about 1.8 million women suffer severe physical violence each year. These data further suggest that a similar number of husbands are victims of violent acts by their wives.* Also, women who experienced severe violence were 150 percent more likely to inflict severe violence on their children than women who did not.

Other Forms of Family Violence

In the same study, the most frequent form of family violence was between siblings. Almost 5 percent of the children in the sample had made threats with or used a knife or gun against a sibling in their lifetime. Severe sibling violence was much more frequent in families in which parents were often violent toward their children or toward each other; specifically, sibling violence occurred in 100 percent of such households as compared with only 20 percent of households in which parents did not use violence toward their children or toward each other.

Children who were victims of parental violence were more likely to use violence against the parents. Among those children who had been hit the most by their parents, 50 percent used violence in return. On the other hand, less than 1 in 400 of the children who were not hit by either mother or father were violent toward a parent.

Straus et al. (1980) found violence to be widespread among families. The study documented the occurrence of different forms of violence within the same families. Families in which interspousal violence occurred were more likely to direct violence toward children, and children who witnessed or were targets of violence were likely to be violent with siblings and parents.

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* Straus and Gelles (1986) have noted that the meaning and consequences of wife-to-husband violence are easily misunderstood. The greater average size and strength of men, and their greater aggressiveness, mean that the same act (e.g., a punch) is likely to be very different in the amount of pain or injury inflicted. Even more important, a great deal of violence by women against their husbands is retaliatory or in self-defense, since the risk of assault for a typical American woman is greatest in her own home. Nonetheless, "violence by women against their husbands is not something to be dismissed because of the even greater violence by their husbands" (Straus and Gelles 1986).

THE CAUSES OF FAMILY VIOLENCE

The etiology of family violence is complex. Violence is best understood as a symptom associated with the interaction of a number of factors in any given family. One must further take into account the particular vulnerabilities in a child, parent, or family that heighten their susceptibility to particular stresses that may in turn result in violence. Bittner and Newberger (1981) proposed a multidimensional etiological model of family violence, which is diagrammed in figure 3-1. This model summarizes predisposing factors in family violence, which can result from interactions among sociocultural factors and stresses operating at the levels of society, family, parent, and child.

No systematic study has been made of the events that precipitate abusive acts. Some instances are acute and self-limited; other cases are of long duration. Nonetheless, when maltreatment is evident in a child who has been brought to a medical setting for treatment, it is helpful to consider circumstances in the family's life immediately prior to the visit. Clinical experience provides examples of a number of situations that can trigger abuse: a baby who, on a particular evening, would not stop crying; an alcoholic father who was fired from his job; a mother who, after being beaten by her husband, could not contact her own mother; the serving of a eviction notice. Any one of these stresses could trigger violence.

As summarized in figure 3-1, a number of variables can interact in ways that lead to child maltreatment. Examples of each major category of variable are provided in the section that follows. While the focus in figure 3-1 and the material that follows is on child maltreatment, the model is relevant to other forms of family violence as well. In all cases, violence is embedded in a family system that in turn is embedded in broader socioeconomic systems, and in all cases the violence is likely to stem from the interaction of multiple causes.

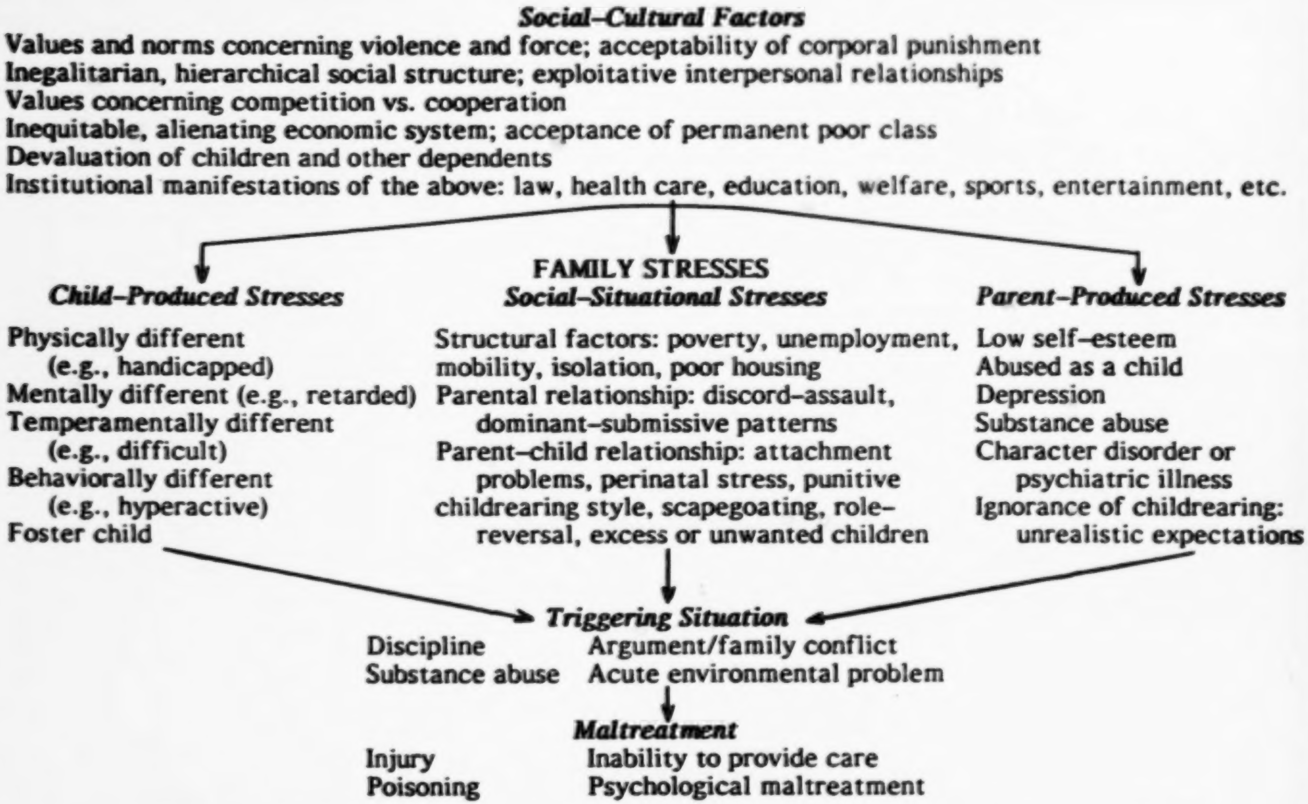
Social–Cultural Factors
Values and norms concerning violence and force; acceptability of corporal punishment
Inegalitarian, hierarchical social structure; exploitative interpersonal relationships
Values concerning competition vs. cooperation
Inequitable, alienating economic system; acceptance of permanent poor class
Devaluation of children and other dependents
Institutional manifestations of the above: law, health care, education, welfare, sports, entertainment, etc.
FAMILY STRESSES
Child–Produced Stresses
Physically different (e.g., handicapped)
Mentally different (e.g., retarded)
Temperamentally different (e.g., difficult)
Behaviorally different (e.g., hyperactive)
Foster child
Social–Situational Stresses
Structural factors: poverty, unemployment, mobility, isolation, poor housing
Parental relationship: discord–assault, dominant–submissive patterns
Parent–child relationship: attachment problems, perinatal stress, punitive childrearing style, scapegoating, role–reversal, excess or unwanted children
Parent–Produced Stresses
Low self–esteem
Abused as a child
Depression
Substance abuse
Character disorder or psychiatric illness
Ignorance of childrearing: unrealistic expectations
Triggering Situation
Discipline
Argument/family conflict
Substance abuse
Acute environmental problem
Maltreatment
Injury
Inability to provide care
Poisoning
Psychological maltreatment

Figure 3–1. Model for understanding child abuse. Adapted from Bittner and Newberger 1981. Copyright 1981 by *Pediatrics in Review*.

Child Factors: Vulnerabilities and Stresses

The realization that children as well as their parents shape the course of family interaction is a fairly recent insight (Harper 1975; Patterson et al. 1975). This perspective has led to the identification of children's characteristics that interfere with normal family functioning. In reviewing the literature on special characteristics of the abused child, Friedrich and Boriskin (1976) noted that behaviors that make children especially difficult to care for and parental perceptions of the child as different or difficult have been associated with abuse.

Included among these special characteristics of abused children are physical handicaps, congenital physical disabilities, mental retardation, schizophrenia, neurological damage, language deficits, and hyperactivity. In addition, low birth weight and prematurity have been linked with abuse—perhaps because of early infant-mother separation or associated special characteristics, such as irritability. Excessive crying or fussiness is another characteristic of abused children. The causal relationship between abuse and developmental disabilities may be bidirectional—developmentally disabled children appearing to be more vulnerable to abuse by caretakers, and abuse and neglect possibly resulting in developmental disabilities.

Parental Vulnerabilities

Parental psychopathology was assumed in the first clinical reports to be the single reason for child maltreatment. Indeed, if present, it may adversely affect a parent's behavior toward a child. However, fewer than 10 percent of abusive parents appear to be psychologically disturbed (Steele 1978). Two factors seem to be critical in determining how vulnerable a parent is to adopting abusive behavior toward a child: (1) the parent's ability to understand and empathize with the child; and (2) the parent's own history, including exposure to violence or deprivation in his or her own family of origin.

Research and clinical findings indicate that parents who use violence against their children were frequently subjected to violence as children (Newberger et al. 1977; Parke and Collmer 1975; Straus et al. 1980). However, "not all parents who have experienced violence as children use violence against their children" (Straus et al. 1980). Thus, caution must be exercised in drawing deterministic conclusions from this association.

It also has been argued that parents who were physically abused as children were frequently deprived emotionally as well. Consequently, as adults they may suffer low self-esteem, depression, and feelings of powerlessness. To compensate, they may achieve goals through coercive tactics applied to those even weaker and less powerful than themselves—that is, to their own children.

Family Stresses

A number of researchers have described an impaired attachment relationship between parent and abused child. A healthy attachment requires reciprocal responsiveness to signals from each other. Factors impairing the reciprocity include perceptual handicaps, developmental disabilities, illness, or irritability on the part of either parent or child. Premature infants appear to be at greater risk for attachment difficulties (Klaus and Kennel 1976) and for later abuse than full-term infants.

Other family factors implicated in child abuse include the absence of one parent through job demands, separation, illness, divorce, or single parenthood; and the social isolation of a family—lack of friends or relations nearby, distance from transportation, lack of a phone, noninvolvement with the community (Newberger et al. 1977). Straus and colleagues (1980) found that high numbers of stressful life events (eight or more) were strongly related to incidents of severe violence against children.

A major stressful condition for many families in which children are abused is poverty. While some investigators of child and spouse abuse have claimed that socioeconomic factors were not related to acts of domestic violence, the very articles containing these claims offer empirical evidence that abuse is more prevalent among those of low socioeconomic status (Gelles 1981). Indeed, a number of studies of family violence support the hypothesis that such violence is more prevalent in low-income families (Parke and Collmer 1975; Gil 1970). Many other social stresses found to be associated with child abuse correlate with lower socioeconomic status, such as unemployment, poor housing, family size, and lack of access to child care (Newberger et al. 1977). However, this conclusion does not mean that domestic violence is confined to lower class households (Straus et al. 1980; Gelles 1981).

Sociocultural Factors

Consensus is increasing on the association between the acceptance of violence as a normative means of socializing children and child abuse. The use of corporal punishment is widespread, and it could be argued that physical punishment of children expresses societal values in a familial context. Controversy reigns over the legal and moral legitimacy of violence toward children as well as other forms of family violence. The support of corporal punishment by such institutions as the United States Supreme Court appears to sanction violent practices in the American home even though some of these practices culminate in serious harm.

The depiction and promotion of violence in the movies and on television may also affect how adults and children approach conflict. Whether media violence is associated with childhood aggressive behaviors remains a subject for lively debate, but consensus is developing that a milieu of violence fosters actions of violence.

Poverty, not parental failure, is cited by Gil (1975) as the principal "abuse" of children, and its continuation as an example of "socially structured and sanctioned child abuse." Many poor children, reported as victims of child abuse and neglect, are placed in foster homes because serious economic and familial problems deprive parents of the resources that enable them to care adequately for their offspring. Too often those foster homes and institutions are also inadequate or even harmful.

RESEARCH ON PEDIATRIC SOCIAL ILLNESS

An innovative approach to etiological research on family violence can be found in our work at Children's Hospital Medical Center in Boston (Newberger et al. 1977, 1986). Our clinical and research team has been interested in a variety of symptoms in children that appear to result from family psychosocial circumstances rather than disease or mishap. These symptoms are associated with the diagnoses of household accidents, ingestions of toxic substances, nonorganic failure to thrive, and child abuse. It appears useful to consider those diagnostic categories as forms of "pediatric social illness," and to investigate the etiological similarities and differences among the four groups.

In our landmark study, a sample of children between the ages of 0 and 4 years was selected from each of the four pediatric social illness diagnostic categories and then matched with control subjects on the basis of age, race, and socioeconomic status. Data on parent, child, family, and social circumstances were gathered through a lengthy maternal interview. Considerable overlap in etiological factors was found as well as some differences among the four groups. Families of child abuse cases differed from families in the other groups in the sheer number of stresses operating on them, as well as the lower poverty level at which they were subsisting. A later cluster analysis (Newberger and Marx 1982) of pediatric social illness data produced three distinct groups: families enjoying "ecological advantage," families suffering from "ecological adversity," and families overwhelmed with "ecological crisis." Cases representing each diagnostic category, as well as control cases, were found in all three clusters. These data support the notion that family violence is one of several possible symptoms of family distress, and that all of the pediatric social illnesses are linked to family and environmental stresses.

RESEARCH ON SEXUAL VICTIMIZATION OF CHILDREN

Child sexual abuse, which is just beginning to receive systematic study, has been defined as "the involvement of children in sexual activities that they do not fully comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles" (NCCAN 1981).

Because fewer than 50 percent of sexually victimized children have any physical symptoms, these cases must be identified through the children's behavioral and psychological indicators of distress or developmentally inappropriate sexual behavior. Despite the difficulties in identification, hospital emergency rooms are seeing increasing numbers of child and adolescent victims of sexual abuse.

Characteristics of Perpetrators

Individuals who sexually abuse children tend to be male. This finding occurs in both clinical and survey reports, with both male and female victims, and in both intrafamilial and nonfamilial abuse. In Finkelhor's study (1979a), 84 percent of the perpetrators were male; in the National Reporting Study, males were perpetrators in 86 percent of the cases of sexual abuse with male victims and 94 percent of the cases with female victims.

Data on convicted offenders distinguish between two types of male offenders involved in sex crimes against children: fixated and regressed (Groth and Birnbaum 1978). The fixated offender would appropriately be labeled a pedophiliac, for whom children are the primary and exclusive sexual object. For the regressed offender, the usual sexual choice is an adult female, but stress or a crisis in family relationships may lead to regression and the choice of a child or adolescent sexual partner. A third type of offender would be the indiscriminately promiscuous adult who chooses children and adults of either sex as sexual objects.

Adults who sexually abuse children are seldom psychotic and may appear perfectly normal to the observer (Summit and Kryso 1978). These offenders also tend to be familiar to the child as family members, friends of the family, neighbors, or babysitters.

Incest

The incestuous family has received considerable attention in the recent clinical literature, most of which has focused on father–daughter incest. As described by a number of clinicians (Summit and Kryso 1978; Weinburg 1955; Cormier et al. 1962), the "endogamous incestuous family" appears on the surface to be quite normal but suffers from serious role distortion. The relationship between the spouses becomes bereft of sexual involvement, and the father–daughter relationship becomes sexual. The involved daughter (usually an adolescent) is described as taking the role of the mother in many ways, due to the mother's withdrawal through illness, depression, or emotional unavailability. The father who engages his daughter in incest has often victimized the mother through violence, coercing her into a passive role. Lustig et al. (1966) described an implicit condoning of the incestuous relationship by the mother and the painful fears of separation and abandonment characterizing all members of the family. The incestuous relationship, it has been suggested, holds the family together. In some cases, however, the pattern is less organized and very promiscuous, with greater role confusion and more blurring of boundaries than in the endogamous family (Weinburg 1955).

Less commonly reported to child protection agencies are sexual relationships among siblings or step-siblings. Survey data indicate that this may be the most common type of incest but the least harmful (Finkelhor 1979a; Nakashima and Zakus 1977). Incestuous sexual experiences are more likely to be repeated over a long period of time than are sexual experiences with nonfamily members (Greenburg 1979).

ISSUES OF DEFINITION AND LABELING

As noted in chapter 1, current reporting statutes define child abuse broadly to include physical and emotional injury and neglect, educational and medical neglect, and sexual abuse. The responsibility of applying these labels to specific situations and behaviors is left to individual practitioners, protective service agencies, and the courts. Clearly, in applying a label such as child abuse and judging the deviance of a parental practice, ambiguous definitions can lead to selective labeling of minority or disadvantaged groups. Turbett and O'Toole (1980) demonstrated that when the same case vignette was presented with ethnicity or income status altered, a difference in diagnosis occurred, with minority and lower income children most likely to be labeled as victims of child abuse.

A recent secondary analysis (Hampton 1983) of data from a national study of the incidence of child maltreatment also revealed dramatic racial and class bias in actual reporting practices in hospitals. Race and class, but not medical severity, significantly discriminated those cases reported to protective service agencies by a sample of 70 hospitals in the 10 States participating in the study.

Difficulties in diagnosing child abuse may also stem from differences among professionals in evaluating the seriousness of the impact of certain parental practices on their children. Giovannoni and Becerra (1979) studied the amount of consensus and difference among professionals and found that they distinguished among kinds of maltreatment and generally agreed as to the relative rank ordering of particular parental behaviors in the seriousness of their consequences for the child. However, significant differences in absolute ratings for degree of seriousness existed among professional groups. Giovannoni and Becerra concluded from their data that greater precision in legal and clinical definitions of child abuse would greatly aid practice in this area.

As long as ambiguity in definitions of child abuse and neglect persists, the problem of biased labeling and professional differences in judgment will lead to preferential diagnoses of abuse and neglect based on criteria other than the characteristics of the caretaking situation itself. Through this process, some families may be subjected to intrusive protective measures when they are not called for, while children in other families may continue to be at grave risk with no intervention provided.

EFFECTS OF MALTREATMENT ON THE CHILD

The effects of physical violence and neglect on the child depend on the child's age and developmental level at the time of the event, the frequency and nature of the experience, and the total emotional milieu in the home. Few well-designed followup studies exist, and longitudinal data on the effects of physical abuse and neglect on children are extremely limited. From available clinical observations, however, it appears that physical violence and neglect affect a child at a number of levels, including physical, cognitive, and emotional development. Furthermore, Friedman and Morse (1976), in following up a sample of 24 abuse and neglect victims, found that in more than 70 percent of the cases, siblings had been injured as well. Research on each of the major areas of negative outcome is summarized briefly below.

Developmental Delay

Numerous studies of abused or neglected children provide evidence of delays in the areas of cognitive, language, and motor development. More severe developmental disabilities are also common (Martin 1980; Solomons 1979). Caffey (1972) warned that shaking infants can result in subdural hematomas that, if left untreated, can lead to mental retardation. A number of studies report that mental retardation in abused children appears to be a direct result of head trauma (Buchanan and Oliver 1979).

Emotional Impairment

Followup studies (e.g., Kinard 1980) of victims of abuse and neglect suggest that the emotional tasks most impaired by aversive conditions in the home are: the development of a positive self-concept; the management of aggression; and the development of social relations with others, including the ability to trust. Moreover, children who have been physically victimized or neglected by a caretaker are likely to feel that they are bad, unlovable, and unwanted. Physically abused children are frequently somber and unhappy, unable to enjoy activities, and rate themselves negatively on self-concept scales (Martin and Beezley 1977; Kinard 1980).

Aggressiveness

Physically abused children were reported to be more physically aggressive with peers than were comparison groups (Martin 1980; Martin and Beezley 1977; Green 1978; Reidy 1977). Neglected children were also rated as more aggressive than controls by their teachers. Green's data suggest that aggression is also likely to be turned against the self among abused and neglected victims. The possibility that abuse experienced as a child may be associated with later violent or delinquent behavior has been a longstanding concern. While Carr (1977) discovered evidence of considerable violence in the childhood histories of delinquent boys, the survey conducted by Straus et al. (1980) also showed clearly that not everybody who was abused as a child becomes an abusing parent.

Abused and neglected children often develop poor relations with peers and adults (Martin and Beezley 1977; Kinard 1980). In a study of 50 physically abused children, Kinard (1980) noted an active avoidance of peers and difficulty in giving and receiving affection in relation to parents and peers. Attachment behavior between abused and neglected children and their parents has also been found to be aberrant, including displays of indiscriminate attachment to adults and/or avoidance of the parent (Schneider-Rosen et al. in press).

EFFECTS OF SEXUAL ABUSE ON THE CHILD

A number of factors determine the psychological sequelae of sexual abuse in the child, including (1) the nature of the sexual activity, its frequency of occurrence, and the use of force; (2) the age and developmental status of the child; (3) the relationship between the child and the perpetrator; and (4) the family's reaction.

Short-term effects of sexual abuse vary with the age of the child but include feelings of anxiety, mistrust, guilt, anger, fear, and depression. Behavioral symptoms may include regressive behaviors (enuresis, encopresis, crying, clinging); difficulties in school; withdrawal from peers; and acting out

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behavior that is sexual, aggressive, or self-destructive (Rosenfeld 1979; Simrel et al. 1979).

Summit and Kryso (1978) reported that victims of incest tend to suffer further sexual assaults from other family members following disclosure, and tend to blame themselves, suffering from depression and impaired sexual relationships in later life. While some claim that sexual abuse is not necessarily harmful to children, knowledge of child development and the imperfect clinical evidence to date suggest that this argument lacks validity.

Information on the long-term effects of sexual abuse is extremely limited and no systematic longitudinal data on childhood victims of sexual abuse exist. The only available information has been obtained from clinical reports, largely retrospective in nature, which show that children who have experienced single incidents of sexual abuse by a strange adult and are supported by their families seem to suffer fewer long-term effects, although short-term effects occur and must be dealt with. Children abused by family members for a long time, however, usually have less family support available following disclosure. Indeed, the child may be viewed as a traitor, responsible for "breaking up the family." If forced to testify in court, such a child must bear the burden of guilt for complicity in the sexual activity, disrupting the family, and possibly sending a family member to jail. Hence, in these cases, it is difficult to separate the long-term effects of sexual abuse from the disturbed family dynamics and the aftermath of disclosure of the sexual activities.

SPOUSE ABUSE

The literature on spouse abuse, like the literature on other aspects of family violence, is characterized by competing definitions and points of view. Most of the research focuses on *wife abuse*, which appears to be by far the more prevalent problem. Parker and Schumacher (1977) defined wife abuse or battering as a "symptom complex of violence in which a woman has, at any time, received deliberate, severe, and repeated (more than three times) demonstrable injury from her husband with the minimal injury of severe bruising." While this definition implies that to qualify as abuse the husband's behavior must leave some evidence on the woman's body after the incident is over, other theorists (e.g., Weitzman and Dreen

1982) consider any kind of physical violence, with or without bruising, as abusive. Similar definitions have been proposed that do not specify gender of victim and perpetrator.

The "discovery" of wife abuse as a social problem appears to have occurred in the 1970s with the rise of the women's movement (Pfouts and Renz 1981). While previously viewed as a psychopathological, sadomasochistic marital relationship of concern only to the particular parties involved, wife abuse has more recently been defined by feminists as a problem

> not of the individual but of a patriarchal society in which men held disproportionate power over valued resources and in which women were subservient to men both within the marriage and in all important facets of society (Pfouts and Renz 1981).

Also, while wife abuse was initially considered to be a problem of the lower socioeconomic classes (Goode 1971), research now demonstrates that wife abuse crosses all socioeconomic strata (e.g., Straus 1977–78). Powered by the feminist movement, recognition of the pervasiveness of wife abuse has led to stronger legal support for the rights of abused women and programs designed to help the abused wife (Nichols 1976; McShane 1979; Costantino 1981).

The research literature on wife abuse contains at least two major perspectives—the personological and the sociological. *Personological* research is oriented toward describing the personality types of individuals who engage in violent relationships. For example, Ponzetti et al. (1982) suggested five characteristics of the male abuser: (1) inexpressiveness; (2) alcohol and drug abuse; (3) emotional dependence; (4) difficulty with assertiveness; and (5) personal experience with family violence—either as observer or victim. Moreover, for the personologist, abused wives share similar characteristics with their abusive husbands, including childhood histories of family violence, dependency conflicts, and a narrow range of coping responses (Weitzman and Dreen 1982). Abused wives have also been viewed as victims of "learned helplessness," having acquired early in childhood the belief that men and not their own behaviors control their lives (Walker 1977–78).

The personological approach to spouse abuse can lead to a focus on such characteristics of abused *wives* as a sense of incompetence and unlovableness, guilt and shame, and a pervasive sense of hopelessness (Hilberman and Munson 1977–78). The *sociological* approach, by contrast, starts with the premise that violence is a normal feature of contemporary society, not just a problem for a particular type of wife (e.g., Goode 1971; Gelles 1974; Straus 1977–78). Goode (1971) noted that patriarchal social systems are based on an unequal distribution of power, and that in the family, as in other power systems, the threat of force underlies all interactions. Unequal power roles have become so internalized in family members that some wives report they believe it is acceptable for a husband to beat up his wife every once in a while (Gelles 1976).

The recognition of wife abuse posed a recurrent question: Why do abused wives remain in abusive relationships? Gelles (1976) pointed to three factors that influence the abused wife's decision to seek help: (1) the less severe and the less frequent the violence, the longer a wife remains with her husband; (2) the more a wife was struck as a child by her parents, the more likely she is to remain with her abusive husband; and (3) the fewer resources and the less power the wife has, the more likely she is to stay with her husband.

Straus, Gelles, and Steinmetz (1980) provided strong documentation for their view that wife-beating is part of the way of life for American families. They also noted, however, that violence between husband and wife is not a one-way street. While husbands perform almost all types of violent acts more often than wives do, wives are more likely than husbands to kick or hit with objects. Straus and his colleagues suggested that differences between husbands and wives in violent behavior may be related more to the smaller size, weight, and muscle development of most women than any greater rejection of physical force on moral grounds. Nevertheless, they concluded that wives are victimized by violence in the family to a much greater extent than husbands, and consequently should be the focus of remedial efforts.

WHAT INTERVENTIONS WORK BEST?

Little is known about the interventions that work best with families needing protective services. The interventions currently available include individual psychiatric treatment for violent family members, family treatment, parent education, and provision of day care, homemaking, and other concrete services. Efforts to prosecute parents who severely abuse (physically or sexually) their children have also increased recently.

A federally funded 3-year evaluation of 11 service projects (the National Demonstration Program on Child Abuse and Neglect) by Berkeley Planning Associates, though methodologically flawed, provided some provocative data (Cohn 1979). "Severe reincidence" of abuse occurred in 30 percent of the families served while the families were in treatment. Reincidence was lowest when well-trained workers handled intake and treatment planning. In addition, serious reincidence was most likely to occur in those families in which the initial abusive incident was most serious, indicating that such families were in particular need of highly trained workers and intensive services. Another noteworthy finding was that workers felt that the potential for future mistreatment was reduced for only 42 percent of the clients served. When service programs were compared, the percentage of "successes" as rated by workers was highest for those clients receiving *lay services* such as Parents Anonymous, a lay counselor, or parent aide.

In her report on the National Demonstration Project Evaluation findings, Cohn also noted the relatively low rate at which children under the care of protective agencies received therapeutic treatment, despite the frequency of behavioral maladjustment. Kinard (1980), in a more systematic study of the effects of abuse on children's emotional status, also made a strong plea for systematic therapeutic attention for abused children. Finally, in professional decisionmaking about intervention in families in which child maltreatment has occurred, the need for interdisciplinary collaboration was noted by many (e.g., Newberger and McAnulty 1976; Bourne and Newberger 1980; Giovannoni and Becerra 1979).

LIMITATIONS TO RESEARCH EVIDENCE

While knowledge in the area of child maltreatment and family violence has expanded considerably since the work by Kempe and his colleagues (1962), the field is still in its infancy (Gelles 1980). Replicated studies are few, and theory remains rudimentary. While we know more than we once did about incidence and some of the factors associated with family violence, we still cannot explain why some families with these characteristics are violent or neglectful toward their children and some are not. Research on sexual abuse is in the early stages, and well-designed studies on the long-term effects of violence and sexual abuse of children are rare. Moreover, well-designed intervention studies are virtually nonexistent.

Current models of the etiology of family violence are complex and difficult to implement or test through research, which of necessity must limit the number of factors studied at any one time. The implications of these behavioral and social science etiological models for clinical practice are also complex. Identification of many levels of causation implies that intervention or prevention efforts at any one level, such as that of the individual parent, may not be sufficient.

While available information about family violence has implications for clinical practice and policy, much is still unknown. Unfortunately, current findings fall far short of providing adequate answers to some of the questions of greatest interest to clinicians (e.g., those concerning the best intervention strategies and the effects of maltreatment on children).

SERVICE NEEDS

Given the widespread incidence of family violence, health and mental health practitioners, as well as educators, will inevitably encounter children and families in whose lives family violence is a reality. How will professionals recognize these social problems and the need for intervention? What will they do when they encounter family violence and believe that intervention is necessary? How will they deal with the family, with their own difficult feelings, and with other professionals who become involved with the family?

Working in this area of clinical and professional practice is extremely difficult. Feelings run high, and action is often lacking. Moreover, failure to recognize the problem can have profound implications for the welfare of children. Territoriality among professionals in these cases can be an added and serious complicating factor. Clearly, any training that promotes the sensitivity and the ability of the professional to recognize and deal effectively with these cases, to work well with other professionals, and to feel confident that the choice of intervention is based upon a secure knowledge base would be of great value. In the chapters that follow, we describe our own experiences at Children's Hospital, with the goal of helping professionals at other institutions develop effective ways of dealing with family violence.

Chapter 4

The Children's Hospital Program on Family Violence

Concern with the problem of child maltreatment began at the Children's Hospital in the mid-1960s, in response to the passage of a mandatory child abuse reporting law in Massachusetts. At first, Children's Hospital, like other medical facilities, was ill-equipped to deal effectively with the new responsibilities imposed by the law. Moreover, there was a critical shortage of personnel in the Department of Public Welfare, which was the State agency designed by law to receive reports of child abuse cases and to provide protective services. Thus, while individual physicians reported cases of inflicted injury to the Department of Public Welfare, the resources available to provide protective services were severely limited. The rate of reinjury in children whose cases had been reported appeared quite high to all observers, and the hospital personnel as well as Welfare Department staff agreed that a more systematic program of case-finding, evaluation, intervention, and followup was essential.

In the 1969-70 hospital year, the financial and human costs of child abuse were measured through a study of length and expense of hospital stay and frequency of reinjury to children. So great was the cost and so high the reinjury rate that a review of existing knowledge and programs throughout the United States was undertaken. Cities such as Denver, Los Angeles, San Francisco, and Pittsburgh were visited to see the programs that had been developed in response to the passage of mandatory reporting laws in other States. In some of these settings, most of the responsibility for dealing with cases of child maltreatment rested in the hands of social service personnel, with physicians largely out of the process. Cities where physicians were more actively involved in the child maltreatment programs appeared to have a more effective approach.

THE TRAUMA X TEAM

As a result of such observations, Children's Hospital developed a hospital-based child abuse consultation unit that included representatives from community-based social services organizations, e.g., the Massachusetts Society for the Prevention of Cruelty to Children and the Department of Public Welfare. This interdisciplinary, interagency consultation unit, the Trauma X Team, was formed in 1970.

The euphemism, Trauma X, defined as "a syndrome with or without inflicted injury in which a child's survival is threatened in his or her home," was adopted with the specific intention of focusing on risk to the child. We preferred this focus to a punitive concern with a family that was having difficulty providing adequate protection and/or nurturance for the child. Our adoption of the term Trauma X rather than, for example, "battered child," was just one expression of our general emphasis on violence and neglect as problems of family systems rather than as attributes of pathological parents. Outsiders might argue that the Trauma X Team clearly deals with cases of abuse and neglect, but viewing these children as the products of family violence, which may also take other forms less often seen within the pediatric medical setting, fits better with our general philosophy.

To assess the impact of the new child maltreatment management system, costs were compared of treatment before and after formation of the Trauma X Team. The data revealed that the average length of hospital stay decreased from 29 to 17 days after formation of the team; moreover, the injury rate declined from 10 percent to 1.7 percent. Setting up the team undoubtedly had other salutary effects as well, such as heightened institutional visibility for problems of family violence. Further information about reductions in "the literal and human cost of child abuse" following the introduction of the Trauma X management system can be found in Newberger et al. (1973).

Research and service programs associated with the child abuse consultation process were at first supported in part by a grant from the Office of Child Development in the Department of Health, Education, and Welfare (OCD-CB-141). The hospital later assumed the salaries of Trauma X Team members originally supported on grant funds as well as other personnel yet to be described (e.g., family advocates, certain Family Development Clinic staff). Currently, between 125 and 150 cases of maltreatment are reported to the Department of Social Services each year. The Trauma X program now operates under the sponsorship of the hospital's administration, with a view to fostering strong collegial relationships among the participants. Cooperative relationships have developed among the hospital's Social Services Department (which numbers 50 workers), the members of the Trauma X Team, the hospital's Office of Legal Counsel, and public and private family service agencies.

Ongoing research conducted by the child maltreatment program staff reveals that the Trauma X Team continues to perform a vital function for the hospital and community. A record review of 280 Trauma X cases seen between 1978 and 1981 revealed that 201 (71.8 percent) of these cases were admitted through the hospital emergency room. Another 68 cases (24.3 percent) were transferred from other hospitals or outpatient clinics and either admitted or seen on an outpatient basis only. These Trauma X cases included 29 children (14 percent) with bruises, 37 children (18 percent) with burns, 25 (12 percent) with skull fractures, 21 (10 percent) with bone fractures, 25 (12 percent) with head injuries, and 26 (13 percent) with poisonings, as well as other problems. The severity of injuries ranged from fatal in 3 children (.01 percent) through life threatening in 30 children (15 percent), serious in 97 children (48 percent), moderate in 116 children (38 percent), and minimal in 31 (15 percent) children. Eighty percent of the children were under 5 years of age; 50 percent were under 1ë years.

Child abuse reports were filed on 57.5 percent of the cases seen by the Trauma X Team. Only 16.8 percent of the cases on which the team consulted were discharged to their homes without being provided with services from the Department of Social Services. Of the remaining children, 57.8 percent went home but were provided with services, 5.1 percent were placed in foster care with a relative, 15.2 percent were placed in foster care with a nonrelative, and 2.7 percent went into residential treatment. In more than 25 percent of the Trauma X cases, care and protection petitions were filed by either Children's Hospital or another agency involved with the family.

THE FAMILY DEVELOPMENT STUDY

The clinical experiences of the Trauma X Team at Children's Hospital led to the creation of a family violence research center, the Family Development Study. The focus of this research program has been on pediatric social illnesses, i.e., on those childhood medical conditions that have familial, child developmental, and environmental antecedents. Child abuse and neglect, accidents, poisonings, and failure to thrive all meet these conditions. Together, they account for a major share of the mortality of preschool children, and each of them often has significant psychological and physical sequelae.

Much of the work of the Family Development Study has been motivated by the desire to help develop a national and universal classification system that would focus on both causal characteristics and direct treatment and intervention more appropriately and effectively than has previously been the case. For example, the roles of the child and the environment are typically overlooked in family violence cases when a disproportionate reliance is placed on harmful acts and perpetrators. Moreover, clinical approaches to accidents, poisonings, and failure to thrive are often limited by implicit conceptual models of chance occurrence, as implied by the names of these conditions. These diagnoses serve to direct clinical attention and treatment to the child's physical symptoms, while the familial and environmental antecedents and concomitants of the symptoms are ignored.

In order to develop a more adequate illness classification system for these social illnesses, members of the Family Development Study research team designed a controlled epidemiologic study in which 560 mothers were interviewed and medical data on their children were reviewed. Pediatric social illness cases and control group families were matched on age, ethnic status, and socioeconomic status. The data from several analyses support the central hypothesis that these social illnesses are related and that their common etiology includes important elements of stress in the family before, during, and after the birth of the child. (For more information, see Newberger et al. 1977; Bowles et al. 1985.)

THE FAMILY ADVOCACY PROGRAM

A Family Advocacy Program was an important outgrowth of the work of the Family Development Study. When designing the interview to assess such stressors as limited access to essential services and general social isolation, the research team was faced with an ethical dilemma: could the pressing problems that were likely to be discovered then be ignored? Our group decided to accept this responsibility. Consequently, when interviewing for the Family Development Study began in December 1972, a family advocacy program was also instituted. By working to assure access to essential services such as housing, health care, child care, education, and legal aid, the family advocates endeavored to improve the environmental circumstances in which childrearing was embedded and to foster the optimal functioning of participating families.

The Family Advocacy Program appeared to be an extremely useful innovation. By working with parents around specific environmental and social problems, the advocates helped them develop a sense of personal efficacy and control. The parents began to see themselves not as passive victims but as active agents better able to control and deal with their own children. Through home visits, telephone calls, and office visits, the advocates developed personal and intensive contact with families and were thus able to help them in numerous direct and indirect ways, e.g., persuading a landlord to restore heat or helping families obtain affordable legal aid. The Advocacy Program, like the Trauma X Team, helped both to increase the visibility of child maltreatment cases and to orient attention to the more general problems of family stress and family violence.

THE FAMILY DEVELOPMENT CLINIC

An outpatient clinic, the Family Development Clinic, was set up in 1972. This clinic specializes in the interdisciplinary assessment and treatment of children who present with various physical and behavioral symptoms indicating that they are at risk of abuse or neglect. The clinic was designed to serve several functions: (1) to provide continuing aftercare services following hospitalization to pediatric social illness cases whose physical conditions had warranted inpatient treatment; (2) to divert children from hospital admission when, despite urgent family crises that might signal the potential usefulness of a "social admission," the children could be sustained safely in their homes; and (3) to organize the specialty resources at the hospital more effectively to deliver services to multiproblem families, and to consult with nonmedical professional personnel involved in their care.

The core staff for the Family Development Clinic consists of medical personnel (generally two pediatricians and a nurse practitioner), a social worker, and a psychologist. As part of their training, other personnel (for example, pediatric and psychiatry residents, visiting behavioral scientists) may rotate through service on the clinic team. The clinic staff regularly hold planning meetings every Wednesday afternoon and see patients Thursday afternoons. Other meeting times are arranged when patient schedules demand it.

Referrals to the clinic come from a variety of sources, including the Department of Social Services and the Juvenile Court. Generally, the clinic is asked to conduct a full social-psychological-medical evaluation to determine whether the child has been the victim of abuse or neglect, and to make recommendations concerning custody and services. All evaluations are conducted by an interdisciplinary team, composed typically of at least one medical professional and one social service professional, with the frequent inclusion of visiting professionals interested in problems of family violence. Often, additional information is sought from other institutions where the child—and perhaps the parent—has been seen. Further assessments may also be obtained from specialists such as neurologists and psychiatrists within the hospital.

An overview of Family Development Clinic intakes between July 1, 1981, and June 30, 1982 provides some useful information about the children seen by this outpatient service. In this 1-year period, 82 children were evaluated. Sixty-two percent of the children were below 5 years of age: 24 percent were less than 2 years old. The basis for the referrals included suspected neglect, physical abuse, sexual abuse, and emotional abuse. Often, personnel from schools or courts had determined that evaluations were necessary not simply because of overt signs of physical abuse but because of such characteristics as excessive thinness and apparent malnutrition, self-abusiveness, severe behavior problems, developmental delay, or poor hygiene. As part of the evaluation and recommendation process, clinic staff spent time not only in the clinic but also in courts, schools, other medical settings, and the clients' homes. While many of the cases were of a first-time nature, others had been coming to the clinic for evaluation and referral for years.

DEVELOPMENT OF A CLINICAL TRAINING PROGRAM

The establishment of the Trauma X Team and Family Development Clinic represented an important response to one manifestation of family violence as it appears in the pediatric medical setting. However, the core professionals involved in these two units became convinced that additional steps were necessary to improve the handling of child maltreatment cases at Children's Hospital and to contribute to general knowledge about family violence as well. The concern of these core professionals (a pediatrician, an attorney/sociologist, a social worker, and a nurse practitioner) stemmed from the high incidence of family violence cases at the hospital. The physical symptoms of child maltreatment and other forms of pediatric social illness could appear in any medical context. Having consultation units available was not sufficient if other hospital personnel did not recognize and respond to such symptoms in their patients. It was clear that broad professional education was essential so that practitioners in a variety of specialties would know how to interview families regarding questionable symptoms and how to interpret the information they obtained.

To meet the needs for training in family violence, the core group of family violence professionals at Children's Hospital obtained support from the National Institute of Mental Health (NIMH) for a clinical training program—the "Model Hospital-Based Training Program on Family Violence." A major element of this training program was inservice education, an effort that was already well underway when grant support was obtained.

Because inservice education is both an essential task and one that can be accomplished without external funding, we describe our own teaching program in detail here. Since the experience of the pediatric, psychological, and sociological fellows has implications for all efforts to improve family violence training through an interdisciplinary training approach, their experience and the implications of their experiences for training are also discussed.

INSERVICE TEACHING

The inservice education program was aimed primarily at pediatricians because that group appeared most focused on the treatment of physical symptoms and least responsive to the more general problems in which family violence is embedded. The content of training sessions was designed to be somewhat specific to the discipline addressed, but also to include a review of the psychosocial factors implicated in the etiology of family violence. Attention was given to the concept of child abuse as a subsidiary form of family violence, the problems of labeling among poor and ethnic minority families, the related problems of "missed" or undiagnosed maltreatment cases among middle and upper class families, and the need for prompt recognition of cases to facilitate careful decisionmaking in case management.

When the training program was initiated, the project directors had already participated in inservice training at a number of different institutions. For the current project, each of the relevant clinical chiefs was contacted to arrange teaching on family violence. All training directors (and some chief residents) were informed of the objectives of the program. This undertaking involved a careful and diplomatic effort to engage the clinical services, whose emphasis has traditionally been biomedical, with little or no attention to psychosocial issues. Each department already had its own special teaching exercises and training techniques, and these had to be respected as cross-program cooperation was enlisted.

Another priority of the program was to obtain access to the conferences that had active participation by the senior staff and members of the visiting medical community, for example, grand rounds on the medical, orthopedic, and surgical services. It was hoped that persuading senior professionals of the value of multidisciplinary approaches to family violence would increase the likelihood of achieving the goals of the program. Many of these senior professionals, specialists in their own field, were understandably reluctant to embrace programs that appeared to mean taking on broader responsibilities for ensuring the welfare of children and addressing psychosocial issues traditionally outside their areas of expertise. Thus, approaching these services was a delicate and difficult task involving personal visits and gentle persuasion. The effort was more than worthwhile, as the chiefs of medical services typically had a tremendous influence on the junior staff, often serving as "ego ideals" whom the young physicians wished to emulate. In teaching hospitals where the emphasis is on training in technical skills, it is very important to convince senior staff of the value of serious attention to family issues. When senior physicians do not think it useful to talk to families, they find other things for their interns and residents to do, thus denying these trainees experience in dealing with families and communicating the view that talking to families about their problems is unimportant.

In the departments of social work, nursing, and psychiatry, there was generally greater acknowledgment of the significance of understanding family violence for clinical training. As part of their own training, professionals in these areas typically had been oriented to a concern with interpersonal issues and an understanding of the importance of family relationships for the well-being of the individual. Consequently, the program staff encountered less difficulty engaging members of these departments in the training program. Indeed, the challenge was to strengthen the role of these professionals—particularly in the female-dominated professions of nursing and social work, which are often looked down upon by physicians.

In addition to enlisting the involvement of senior medical staff, efforts were made to educate the pediatric trainees on issues of family violence. At Children's Hospital, as at many other training hospitals, junior medical personnel are loosely grouped into two categories—interns and residents. Interns are usually recent graduates of medical school. Residents generally have 1 to 5 years postgraduate clinical experience; several in each training year have more extensive clinical or investigative backgrounds. About 40 percent subsequently elect careers in clinical practice; the other 60 percent go on to subspecialty training and academic work, which frequently involves both research and teaching.

In teaching hospitals, the junior staff have the actual contact with families. Thus, it is important for interns and residents to have the knowledge and practical skills to work effectively with families. They need to realize that certain symptoms may mean that further investigation is desirable. For example, if a child with a fractured leg is visited by a mother with a black eye, physicians should consider the possibility of family violence and not just confine themselves to fixing the fracture.

We assumed that by addressing pediatric fellows directly and relatively early in their training, we could help improve the competency of the pediatric field to come to terms with the complexities of the treatment and prevention of family violence (a problem with more dimensions than the purely medical). Thus, training efforts were addressed both to senior physicians who could, through their influence, enhance the "respectability" and value of a multidisciplinary approach to family violence, and to junior physicians who could develop enlightened perspectives and particular kinds of interpersonal skills before becoming locked in to the narrower perspectives that characterize many specialty areas.

As the training program evolved, several approaches were used in the teaching sessions on family violence. During the first year of the program, an effort was made to get project staff included on the roster of every medical specialty's inservice teaching schedule, as well as the hospital's medical grand rounds and postgraduate rounds. Richard Gelles, the first postdoctoral fellow on the training grant, was enlisted in this effort. Dr. Gelles is a sociologist who already had established a national reputation for research in the area of family violence before he became a social science fellow on the training grant. In addition to publishing several books, chapters, and articles on family violence, he had collaborated with Straus and Steinmetz on the major study of family violence discussed in chapter 2 and published in the book *Behind Closed Doors: Violence in the American Family* (Straus et al. 1980).

A second approach to inservice education, case-focused teaching sessions, was used whenever a particularly difficult or upsetting case appeared on one of the hospital's medical or surgical services. These might include cases where serious disagreement occurred among medical and social service staff as to whether the child was at risk or whether the case should be referred to the Trauma X Team. For example, when a child was diagnosed as having subdural hematomas of unclear etiology, the physician focusing narrowly on the symptom might insist on an accidental explanation, while the social worker and nursing staff might be convinced that social factors placed the child at great risk, even if the etiology was unclear. Such disagreements had serious implications, because if physicians in the emergency room missed a case of inflicted violence—for example, because of a missing medical record or a failure to ask the right question—the child might return later with more serious injuries. Other types of upsetting cases included those involving attempted or completed murder, which aroused strong emotions in all involved. In these situations, an attempt was made to set up a case-focused teaching conference, led either by Trauma X staff or, better yet, by the chief resident or chief of service in the division to which the child had been admitted. At these sessions, the course of case management would be reviewed with focus on psychological and social data as well as the medical data. In each case, an attempt was made to understand the etiology and plan an intervention; however, it was not possible in all cases to come to closure on whether the injury was inflicted or not.

A third approach to inservice teaching was carried out within disciplinary groups and was facilitated by the introduction of pediatric fellows into the training program. In this approach, pediatric fellows used case consultation with members of their own discipline as an educational vehicle, ***whether such consultation was solicited or not***. This approach was found to be most useful when a sharp split or tension arose among staff as to how to manage a case.

Over the 3 years of the training program, the Trauma X faculty members and fellows conducted a total of 150 inservice teaching sessions within the hospital. They taught at almost every disciplinary and specialty inservice seminar. Reactions were positive, and relations between the Trauma X Team and the hospital staff improved. The Trauma Team began to be consulted regularly by physicians from medical units who had previously been reluctant to deal directly with issues related to family violence. While difficult cases continue to split staff in decisionmaking, procedures have been established to address these splits and facilitate collaboration.

Chapter 5

The Model Hospital-Based Training Program on Family Violence

Obtaining Federal grant support was very useful both in achieving the expanded level of inservice education just described, and also in instituting two new components—a Family Violence Seminar and a fellowship program for pediatricians and behavioral and social scientists. Underlying all training program activities was a common set of goals, including heightening the professional awareness of the content and complexity of social problems associated with family violence, expanding the repertory of conceptual and practical tools of practitioners, promoting interdisciplinary communication and collaboration, and stimulating critical scrutiny of present knowledge and practice. It was hoped that exposure to new theory and methods would prompt participants to rethink and redirect professional commitments.

Training in the project focused on professional concepts and skills; however, components of the project, especially the weekly Family Violence Seminar, were also conceived as laboratories for investigating the basis for current beliefs and practices concerning family violence. One of the goals was the generation of a state-of-the-art training curriculum for guiding future research and practice. In other words, we hoped to develop an improved training model on family violence and, out of this, a curriculum that could assist future clinical management at Children's Hospital and other hospital facilities.

FAMILY VIOLENCE SEMINAR

The Family Violence Seminar was a key component of the training program, providing a weekly forum for presentations on family violence by researchers, policymakers, and clinicians. The seminar met every Tuesday morning for an hour and a half, with an average weekly attendance of 25 participants representing all professional groups at the hospital, as well as external health, mental health, and social service agencies and academic institutions. A core group of participants attended regularly, while many others came periodically. Speakers were invited from within and outside the hospital and from academic, government, and clinical settings to share current research, issues in public policy, and innovations or expertise in clinical practice with the participants.

The Family Violence Seminar was designed to meet a number of goals identified by those hospital clinicians who were most involved in practice with victims of family violence and who had formulated the proposal for the training program. These goals included the following:

1. Updating knowledge based on research, policy, and practice in the area of child maltreatment and family violence
2. Providing a forum for discussion among clinicians of different disciplines and among clinicians and researchers
3. Providing an opportunity for critical examination of the assumptions and concepts guiding their clinical practice
4. Considering current views on the etiology of family violence and sexual abuse, and the implications of these theories for practice
5. Generating new conceptual models to guide the investigation of issues in family violence

An additional goal specific to the training program was to develop a curriculum on family violence useful to other professionals in the field. To this end, all seminars were taped. The onset of the training program provided a budget to free some of the project codirector's time to organize the seminar and to offer a modest honorarium for speakers.

To institute the Family Violence Seminar, an initial planning session was devoted to determining who the participants should be. A major goal of the seminar was to foster communication and better mutual understanding among the disciplines involved with child abuse cases in the hospital: nurses, social workers, pediatricians, psychiatrists, and psychologists. While social service and nursing staff had already expressed interest in attending the seminar, much thought had to be given to attracting pediatric staff who saw issues of family violence as generally outside their domain. Notices were placed in the weekly schedule of medical teaching events. Chiefs of services were contacted by phone to inform and invite them to the seminar. Much consideration was accorded the selection of speakers who might appeal most to the medical staff. Yet, overall, these efforts failed to attract much participation from the medical staff. The pediatricians who attended were those most intimately involved with the Trauma X Team, or already quite interested in the problem of family violence. Several pediatricians in ambulatory services attended occasionally, and one community pediatrician attended regularly for the first year of the program.

With social workers, nurses, and psychologists, the opposite problem was anticipated—so many would want to attend that the seminar would become too large to foster the kind of discussion desired. After much discussion, all social workers were invited to attend the seminar. The nurse on the project spoke with the head of nursing at the hospital regarding the project, and she assigned three nurses to attend the seminar. Selected psychologists and psychiatrists at the hospital and an affiliated child guidance clinic were also invited. Chiefs of all disciplines were invited. In addition, several social service agencies such as Parents' and Children's Services and the Department of Public Welfare were contacted to see if they would like to send one or two representatives. Several local behavioral and social scientists involved in research on families were notified. In all, a total of 80 people were invited to attend the seminar, in addition to the announcement in the Medical Area Newsletter. Of this group, 61 attended at least one seminar, and a core group of 25 attended at least half of the seminars in the first year. The group composition, by discipline, was remarkably similar for all 3 years of the program, though many of the individual participants changed.

Over time, as word of the seminar spread, other members of the hospital community as well as representatives from outside agencies and universities asked if they might attend, and they were invited. Frequently, speakers invited for one meeting asked if they might become regular group members as well. Ultimately, representatives joined the seminar from a wide range of outside programs and projects, including an innovative family therapy outreach project from a mental health center funded by the State protective service agency; a counselling service for men who are violent toward their wives; several research projects, including a longitudinal study of the effects of abuse on children and a historical research project on sexual and family violence; a private child advocacy foundation; and the New England Resource Center for Protective Services.

The seminar went through some evolution in format through the first year. That period was considered experimental and participants were urged to reflect critically on the seminar content and process in questionnaire evaluation and in several open discussion sessions. The first format used was a colloquium. Invited speakers presented for as long as they wished, although they were advised to leave time for discussion. Weekly topics were varied and far-ranging. For example, one week the project codirector, a hospital attorney, spoke on "Family Violence and Criminal Law;" the next week Richard Gelles, a sociologist and program fellow, presented the results of a National Survey on Family Violence. These speakers were followed by a presentation on "Violence and Children's Television." Speakers in the first half of the first year were drawn mainly from the Boston area and focused on current research issues in family violence and sexual abuse, with occasional speakers on clinical or public policy issues.

In a questionnaire evaluation midway through the first year, the seminars were rated very positively on the whole. However, two strong recommendations were made: (1) to provide more discussion time and (2) to address clinical issues and applications for all the topics presented, even when the presenters focused only on research. These recommendations were followed. In the second and third years of the program, the seminars were organized into a modular format in which selected topics were considered during three presentations and one full session for discussion. This format provided more continuity and an opportunity to reflect on and integrate diverse approaches to the same issue.

The evolution of a group sense occurred slowly over the first year among the regular seminar attendees. It was not an easy process, however. Discussions were often competitive and conflict-ridden. Many members were silent and felt undervalued, in contrast to the "higher status" participants who dominated the floor. A discussion session devoted to the seminar process itself was helpful in bringing silent participants into the discussion and raising group consciousness. Subsequent discussion sessions, however, though involving more members, continued to be conflictual. Frustration built up as participants felt that training program personnel were simply reflecting on the issues involved in the etiology of family problems, but were not really doing anything about them, or anything to improve the hospital practice with such cases. At one session set to discuss courses of possible action, the focus of the discussion was racism in the hospital structure and the responsibility of the seminar group to address this problem. The group was very divided as to what action to take. A newcomer to the seminar, who attended because of her interest in forming a group to study racism as it operated in the hospital, was criticized by two of the seminar participants for having an unworkable idea. The group was unable to agree on any unified goal, feelings ran high, and disciplinary lines often identified factions.

Nevertheless, all participants continued to attend the seminar, and more and more became actively involved in expressing their views. By the end of the year, a regularly attending core group made up of members of all disciplines had emerged, expressing a commitment to attend the seminars the following year and an active interest in helping to plan and structure the next year's agenda.

As the seminar continued in the second year, a sense of a cohesive group, reflecting the contributions of all members, emerged. Discussions often reached an open and personal level as members talked about their own feelings, values, and experiences in such areas as sex roles, victimization, and race relations. The themes of sex roles, inequality, and aggression were prominent in discussions through much of the year, relating to presentations on sexual victimization of children, spouse abuse, and media exploitations of women. Discussions often led to consideration of the implications of these issues for relations among hospital professionals, or between professionals and patients. While at times discussions of personal experiences related to gender or ethnic status became divisive, the overall effect was one of increasing cohesion and willingness to explore feelings and values.

Over time, whether the speaker was a researcher or clinician seemed to become less important. Research findings and ideas were freely discussed and criticized by clinicians, and applications to practice were suggested. Clinicians' presentations were discussed with great interest by researchers, who often were able to introduce relevant research findings throwing light on the clinical experience. The gap originally experienced between the two camps was bridged by a mutual interest in and respect for the others' work. In fact, many a participant remarked, "It doesn't really matter who speaks, or what they say, the discussion is the best part of the seminar."

The seminar was a meeting place for diverse individuals from diverse settings offering different perspectives on the problems of child maltreatment and family violence. As such, it served both intellectual and interpersonal functions. On an evaluation questionnaire, *all* respondents noted that their knowledge had been expanded through the seminar, and many called it a very stimulating part of their week. Academics and clinicians alike indicated that they looked forward to Tuesday mornings, as much to the exchange of perspectives in the discussion as to the presentation itself. Clinicians welcomed the opportunity to step back from their busy, at times overwhelming, caseload to reflect on and learn from a more abstract analysis of factors contributing to family problems. Researchers praised the unique opportunity to hear from clinicians working with families, and to learn from case material something about the clinical issues and frustrations in work with disabled families.

Many clinicians mentioned that their practice with families was affected by the seminar. Some reported an increased awareness of their personal biases and the assumptions they drew upon in reaching conclusions about families. Many indicated an increased sympathy and empathy for all members of the family system, victim and perpetrator alike. Other clinicians became more critical of current clinical and protective interventions with families, and reported more ambivalence about what to do and more powerlessness to effect change. A number of clinicians, including members of the Trauma X Team, indicated that their general approach to cases remained the same, but a stronger foundation of knowledge backed up what had previously been gut reactions. These clinicians reported increased confidence in their work and a growing tendency to advocate strongly for families and related policies.

In discussions of cases at the weekly Trauma X update meeting, which immediately followed the seminar, questions and comments frequently stemmed directly from the previous seminar. For example, following a presentation on the family system in cases of maltreatment, the usual emphasis on the mother's role was increasingly replaced by questions such as: "What about the father?" and "What do we know about the rest of the family?" Seminars on minority families and economic and cultural factors in child abuse directly affected case discussions as well.

The seminar also stimulated other intellectual and training efforts for the participants. A participating lawyer organized an all-day workshop on family violence for juvenile court judges. A participating psychologist was prompted to finish and present a paper on power relations in violent families. On the basis of the success of the first year of the seminar, the Trauma X Team organized a 2-day workshop for State protective service workers.

The seminar also served an important interpersonal function. It allowed clinicians, who worked together in a very pressure- and crisis-oriented atmosphere, an opportunity to get to know one another in a less stressful setting. The developing sense of openness, respect, and cohesiveness among the participants affected overall working relationships.

Trauma X Team members found that relationships with social workers and nurses attending the seminar developed new depth and respect. A firmer footing was established around difficult cases. Working relationships improved and consultation became easier. Fellows were frequently consulted by other seminar participants for advice on a research project, or for information regarding a teaching session. Hospital clinicians got to know and hear from representatives of the State protective service system, and greater respect, understanding, and cooperation ensued, as well as exchange of practical information on particular cases.

Providing the opportunity for professionals to come together to learn and to talk to each other over time was the key element of the seminar. This program element was crucial. It had its difficult and conflict-filled moments, however, and disappointingly, few pediatricians got involved. Persuading pediatricians to take time out from their busy medical schedules to learn more about family violence, particularly its psychosocial aspects, is likely to challenge organizers of training programs in other settings as well. Still, the effort to involve physicians is worthwhile; those pediatricians who did participate found it enormously helpful.

THE JOURNAL GROUP

Toward the end of the first year of the training program, an interdisciplinary journal group evolved. The purpose of this group was to review current theoretical and empirical work in the area of family violence and to design and conduct empirical studies. The fellows were actively involved in research and writing efforts during their traineeship, and each developed papers that were presented at professional meetings and/or published. The journal group provided a congenial and helpful forum for the development of these projects and for trial runs on the papers presented. We would recommend this structure to practitioners in other clinical settings as a valuable format for interdisciplinary collaboration.

FELLOWSHIP PROGRAM

Postdoctoral fellowships were a component of the family violence training program that greatly facilitated the bridging of research and practice in the area of family violence. The fellowships were available to established behavioral and social scientists in the fields of psychology and sociology and to pediatricians with an interest in academic pediatrics and research. Although most settings are not able to provide federally supported fellowships to individuals at the postdoctoral level, the goals of our program and experiences of our fellows are relevant to a variety of alternative approaches (for example, unpaid predoctoral traineeships) designed to bring researchers and practitioners together.

BRIDGING RESEARCH AND PRACTICE

While the Family Violence Training Program was a clinical training program, its purpose was not to make clinicians out of social scientists but to improve the handling of family violence in medical settings by reducing the gap between research and practice. It was hoped that researchers and practitioners working together in a clinical setting would share their knowledge, insights, and perspectives in a way that would benefit everybody concerned with family violence. The training program provided a number of opportunities and structures for interchanges between researchers and practitioners, many of which took place specifically around concrete clinical cases.

The general goal of the fellowship program was to provide advanced training in the area of child maltreatment and family violence in a hospital setting and to foster careers in research on these problems. For pediatric fellows, a more specific goal was to provide intensive clinical exposure to interdisciplinary case evaluation and management as well as exposure to research knowledge and skills in the area of family violence and child maltreatment. For academic fellows already versed in research knowledge and skills, it was hoped that exposure to a clinical setting would promote clinical research on problems of family violence.

Two additional goals of the fellowship program were (1) to provide the wider hospital community with the research knowledge and conceptual skills of the academic fellows through informal consultation, collaboration, and teaching; and (2) to provide the pediatric staff with role model consultants and peers through the pediatric fellows.

To further these goals, a core set of training activities was planned for all fellows. These activities included the following:

- Participation as presenters and discussants in the Family Violence Seminar
- Participation in the Trauma X Team update meetings, case conferences, and rounds—either as observers (academic fellows) or as participating clinicians (pediatric fellows)
- Participation as observers and clinicians in the Family Development Clinic—as observers and supervised interviewers (academic fellows) or as principal clinicians (pediatricians)
- participation as presenters and discussants at other teaching activities within the hospital
- After the second year, participation in a research-oriented journal group

Other training options included participation in the hospital's Child Development Program, Early Childhood Clinic, Sexual Abuse Team, Department of Psychiatry seminar and rounds, and the Failure-to-Thrive Team.

Introducing a training program on family violence requires preparation for dealing with the strong emotional impact of these cases. Our fellows provide, in their own words, clear indications of the kinds of reactions that program supervisors must be prepared to address. For example, in a pediatric hospital, cases of possible maltreatment often differ in their impact on the professional involved with them. In some weeks, cases of possible neglect or nonorganic failure to thrive can come to seem almost routine, even to the novice social science fellow. In other weeks, every case seems to arouse rage or despair. Some children undergoing prolonged hospitalization continue to have heart-rending impact through weeks and weeks of evaluation and review.

> There are cases I came into contact with at Trauma X meetings that I will never forget as long as I live. I can still remember one of the first cases I heard about in Trauma X that continued over weeks and weeks. I remember those cases for the horror of what had happened to the kids and also for the difficulty there was in doing anything to help them.

Direct involvement of behavioral and social science fellows in the provision of psychotherapy (through the Department of Psychiatry) revealed no magical solution here either. Even when diagnoses had been made and agreed upon, and a course of psychotherapy had been recommended and undertaken, progress could be slow and elusive. Social science fellows who had assumed they could have a direct and immediate positive impact on families often brought feelings of frustration to their supervisors in psychiatry as well as their mentors on the Training Program Faculty.

> I never anticipated the level of involvement, of emotional and psychological involvement, with families. I guess I was expecting a small, discrete set of issues that we could address doing diagnostics or in clinics or through psychotherapy that could resolve within a few sessions. I never anticipated the ongoing nature, the kind of pile-up you get, so that just when you think you are making progress in one area, the dike breaks in another area. Yes, you are making progress but it is not like the nice linear progress I was expecting.

Bringing social scientists into a pediatric hospital meant dealing not only with their feelings about cases of family violence but also with their feelings about the cumbersome and imperfect process involved in diagnosing and treating such cases. Indeed, having a clinical training program in family violence meant having outsiders present as witnesses to all the problems of interdisciplinary cooperation and all the repercussions of the gap between research and practice—and again, dealing with the feelings and reactions of both the fellows and the hospital staff as a result of this addition.

For the pediatric fellows, involvement with Trauma X cases was of a more direct, medical nature and often provided a rather different set of experiences. For one of the pediatric fellows, working with the Trauma X Team offered a much more positive experience than he had had earlier in his training.

> I don't think, strictly speaking, that we were working in isolation in my previous experience as a resident—there was usually a social worker involved and we did report to the Bureau of Child Welfare—but the perception was that you were alone dealing with the anxieties and doubts that the different cases raise. Whereas here, the perception was one of close working relationships and of support—and that everybody was dealing with the same emotional burden and you had the opportunity to talk about it.

The presence of the fellows, and their expressions of thoughts and feelings concerning the processes they were observing, unavoidably—and perhaps usefully—had an impact on the medical and social service staff committed to dealing with cases of family violence. Professionals intending to develop family violence programs at other institutions should be prepared to deal with the fact that providing training to outsiders—especially, perhaps, if they are researchers—will affect all concerned.

Whatever disillusionments may have been connected with some aspects of the clinical experiences to which the fellows were exposed, they were also seen as valuable. Social science and clinical fellows alike found that their experience within the clinical services enriched their perspectives.

> The experiences that had the most profound impact on me were the Family Development Clinic and the individual therapeutic and diagnostic work, where I had the opportunity in a one-to-one relationship to apply whatever research was applicable. It wasn't a static process where one takes research and applies it. It was back and forth

and all the time. Clinical work opened up new ideas for interpreting research findings, and research findings were applied to clinical work with various degrees of success.

It's useful for practitioners to have researchers to tell them when they're pinning their diagnosis on a fallacious assertion. I remember a classic example where the clinician decided a fractured skull wasn't due to child abuse because it was administered by a sibling. I asked, "Well, gee, where do you think the sibling learned that kind of behavior?" A whole new discussion ensued with the social service people saying, "The house wasn't a mess. There couldn't be any abuse or neglect." I told them one has nothing to do with the other. On the other hand, the researchers say, "This is clearly a case of such and such," and the clinicians say, "We can't do a darn thing about that. Come up with something useful."

I think this is an ideal setting because the program brings together people of a research background with people of a clinical background around the same data—the same families in the clinic. Certainly, in my own development, the program helped me establish research questions that I thought were important and supplied me with the beginnings of the research tools to attack those questions.

I think I have a more profound appreciation, for example, of childhood accidents. Looking back, probably stemming from a rather optimistic view of human nature, I really used to have the perspective that accidents were much more random. Now I'd want to explore more deeply what led up to an accident. In the past, as a physician confronted by an accident, if supplied with a plausible explanation, I think I would have treated it lightly. Now I feel that in certain instances I would see the accident as pointing to stress, for example, or some family dysfunction. And I'd probe more deeply to assess whether or not there were family issues manifesting in those accidents and needing to be addressed.

There was a fair amount of discussion about some difficult clinical issues and I really enjoyed that. As a small bonus package to a pediatrician, it was of value to be exposed to the area of handicapped children and their treatment. It was very helpful to have the opportunity of working in a multidisciplinary group and to see firsthand what are the common, profound dilemmas that lead to research.

I think clinical training should be part of every psychologist's training. It's too easy to be an armchair psychologist, to elaborate your theories and design your studies in the abstract, without knowing, for example, what it feels like to be a clinician dealing with a case. If researchers are going to talk to clinicians, they have to know what it feels like to work with a child who was beaten up. And if researchers are going to write in a way that is useful for anybody besides journal editors and other professionals—and I think it's their responsibility to do so—then it helps to have some ground-level experience. My experience in talking with mothers and observing mothers and kids interacting behind the oneway mirror in the Family Development Clinic and seeing how cases got dealt with in Trauma X did that for me, made me want to write for a broad audience. For a basic researcher and academician, that kind of real life experience makes you understand the realities you're dealing with, how difficult and complex it is to make the world a better place.

As a researcher, I originally conceptualized family violence in terms of battering—a very narrow kind of conceptualization. Working with the Trauma Team as well as in some of my clinical experiences, I came in contact with a variety of cases that weren't violent in a narrow interpretation of inflicted injury. I can think of a specific case where a child was injured by an automobile door. Irrespective of whether that injury was consistent with the explanation, there were a whole host of other family dynamics which led the clinicians to view this family as a family in trouble and at risk. In terms of the narrow definition of battering with which I came, that child was not battered, but he certainly was a victim of one form of maltreatment.

ISSUES IN CLINICAL TRAINING

The clinical component of the Family Violence Training Program, like the other components, was dynamic, not static. It evolved over time and in response to the expressed needs and concerns of the fellows. In this section, we review the major issues raised by the fellows concerning their clinical training and the changes made in this component of the training program to deal with those issues. Again, both the issues raised and the responses made are relevant to all clinical settings that recognize the need to undertake training on family violence.

Orientation

The fellows, even those with previous clinical experience, expressed a need for orientation to and debriefing after clinical case presentations and clinical observations. No one felt prepared for the emotional onslaught that accompanied hearing about and dealing with case after case of family violence and severe deprivation in the lives of children and their parents. In the Family Development Clinic, academic fellows asked for some explication and discussion of the clinical processes they were observing, such as interviews by psychiatrists and social workers, and assessments by nurses and clinical psychologists. Pediatric fellows requested close supervision on cases with which they were involved, feeling that their previous training had not sufficiently prepared them for parent and family interviewing, negotiating with social service and judicial personnel, or testifying in court. In addition, fellows were eager to learn about hospital procedures and politics likely to affect the management of family violence cases.

A number of steps were taken to respond to trainee requests for expanded supervision and enlightenment. Beginning in the second year of the program, a series of individual orientation meetings was arranged for the pediatric fellows with Ms. Betty Singer, the Trauma X chairperson. In addition, all fellows were assigned an advisor-mentor from the program faculty to facilitate their entry into the training program and hospital, and to provide an orientation and opportunity for discussion of clinical observations and experiences. Advisors and fellows attempted to meet once a week or biweekly. Regular monthly meetings for all fellows were scheduled with the project evaluator to review training activities and issues. Finally, in the third year of the program, an hour was arranged for case discussion following Family Development Clinic appointments on Thursday afternoons. This time was used to discuss the cases seen that afternoon and to generate research questions relevant to the clinical process—for example, issues related to the assessment tools used in studying family interaction.

Association with Psychiatry Department

Some of the social science fellows elected to obtain supervised psychotherapy experience from the hospital's Department of Psychiatry and expressed a need for a closer tie-in between the department and the training program. The fellows desired more discussion of the experience within Psychiatry than was possible during regular supervision on cases. Psychiatry department supervisors tended to assume that the behavioral and social science fellows were well-versed in psychiatric concepts and perspectives. Jargon was often confusing. Both supervisors and fellows sought to clarify the purpose of this training experience.

To facilitate the fellows' integration of this experience, Dr. Carolyn Newberger, a psychologist on the program faculty, took on two additional responsibilities in the third year of the project: (1) supervision of the fellows in diagnostic evaluations and psychotherapy, and (2) leadership of a seminar on psychiatric perspectives where issues related to the connections between research and practice were discussed with the fellows.

Clearly, both the pediatric and social science fellows found their training year to be an enlightening and enriching experience—although they generally did not believe that either the clinical or other components of the training program had radically altered their perspectives on family violence. The absence of radical changes in perspectives is not surprising. Application and selection procedures in a clinical training program such as ours are likely to ensure a certain degree of open-mindedness and freedom from a blaming-the-victim mentality in its trainees. These were precisely the attitudes that were fostered within the training program, along with, of course, both scientific objectivity and clinical sensitivity. Moreover, all the fellows came into the program with a desire somehow to build on their own interests and skills in ways that would be helpful to families and to the eventual alleviation of family violence. In all cases, the program proved consistent with and supportive of these goals.

As a result of their experiences in the clinical services, reality was broadened for practitioners and social scientists alike. The clinicians developed new sets of cognitive lenses through which to view troubled families. The social scientists were brought much closer to real world problems than had been possible in their university settings. Both practitioners and social scientists questioned some of their old answers and began formulating new questions about families. Together, social scientists and practitioners generated research questions, giving rise to a substantial number of investigations, some of which have been completed and some of which are still underway. Moreover, all the fellows are likely to be involved in teaching/training activities for the rest of their professional lives, and all of them believe that these activities have been indelibly affected by their participation in the training program.

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Chapter 6

Professional Roles in the Service and Training Program in Family Violence

THE MULTIDISCIPLINARY CASE CONFERENCE

Family violence services began at Children's Hospital at a time when the problems of child abuse, child sexual abuse, and family violence were only dimly perceived and were often ignored within the medical services. When the Trauma X consultation unit was formed in 1970, communication within the principal human service disciplines was inadequate, and the isolation of the hospital from community service agencies was very evident. The first task was to convene a weekly multidisciplinary case conference involving representatives from the hospital, the public social welfare agency mandated by law to receive child abuse case reports, and two private child welfare agencies with special competencies in the child protection area.

The lessons learned from this experience guided the subsequent development of written hospital guidelines for child abuse case management. These guidelines stipulated particular roles for individual members and for the consultation unit as a whole. A copy of the most recent iteration of guidelines is attached as an appendix. The following six lessons learned from the multidisciplinary conference are worthy of attention in all medical facilities concerned with family violence.

1. *The social work discipline must be central, both in the administrative locus of the consultative unit and in the leadership of the team.* We found that placing the program under the aegis of the hospital's general administration, rather than a particular medical department, gave social work the needed standing. Conferences led by physicians, psychiatrists, and lawyers, no matter how sensitive these persons were to the

process and informed about the issues, often tended to intimidate social workers from the hospital as well as from other agencies. Despite their traditionally lower status, social workers and nurses are most often able to discern and pinpoint the family dimensions of violence or of sexual abuse. Moreover, these professionals have firsthand access to the information on adults, children, and family relationships on which important diagnostic and custody judgments and choices are made. Consequently, conferences are most successful in encouraging a full sense of participation when chaired by a social worker. Moreover, consensus appears to evolve more easily and conflict seems to be tolerated more readily when the chair is a social worker. In medical and legal institutions, the important power perogatives are often held, if not zealously guarded, by professions dominated by men. Giving social workers and nurses, who traditionally have been women, a visible leadership and decisionmaking role conveys to various colleagues the message that these are professionals deserving respect and esteem.

2. *Issues of turf and control are best approached through discussion and patience, not through promulgation of rules, procedures, and rigid stipulations of roles.* Such is the nature of medical specialities. In our hospital, for example, the task of empowering the nursing and social service professionals was initially attempted by drafting edicts and guidelines; ultimately, however, success came through steady and consistent consultation and teaching. That is, only gradually was it possible to persuade certain of the specialty medical and surgical services to relinquish elements of their total control over the patient. Now, after 14 years of inservice teaching conferences and efforts to give higher visibility and respect to the work of social workers and nurses, these professionals can, without the orders or permission of physicians, make direct contact with the consultation team. Occasional carping on the part of certain of the older members of the physician staff remain, but the principle is generally accepted.

Establishing linkages between individual members of the consultation team and counterparts on each of the specialty services was a particularly useful way to gain respect for a consultation group who took a very different approach to patients and their families than had been traditional in a medical setting. Attitudes of support, appreciation, and professionalism were of greater value than the prevalent postures of competition and struggle. Fostering human values in a personal approach to one's colleagues appealed to all participants.

3. *The best decisionmaking derives from discussions where conflict is permitted and different professionals' perspectives can be expressed.* Often, difficult judgments must be based on limited and subjective information. Good decisions require time for sorting out information from inferences and for defining the reliability, validity, and meaning of the information. The tendency on the part of the professionals in medicine, psychiatry, nursing, and social work—based on their professional training and socialization—is to derive pathologic or illness formulations from information about families. An opportunity for open expression of views about strength and health, as well as an understanding of different cultural values and their manifestations in family life, permits development of a better capacity to conceptualize and to acknowledge strength as well as pathology or problems. With this process goes a certain amount of ambiguity and conflict, but the decisions that emerge may be more humane and conducive to better health in children.

4. *Unless issues of class and cultural bias are brought forth explicitly in consultations and case conferences, decisions will, however unintentionally, be influenced by such biases.* We have learned to identify explicitly the socioeconomic status of the family, their culture, ethnicity, and race, and to note specifically the need to consider the family information with respect to the cultural context. Having a mix of professionals from various backgrounds assists enormously in controlling a propensity toward culture-bound value judgments.

5. *The natural tendency for professionals faced with a difficult decision is to call for additional information.* This is especially true if the family is middle-class or affluent, because professionals are frequently reluctant, when a family is similar to their own, to derive diagnoses carrying a negative value judgment. One can hear professionals saying essentially, "Why, they're such a nice, well-to-do family. They couldn't be abusing their child. If we get more information it will become clear that those injuries couldn't be due to abuse." In actuality, preliminary information is often sufficient for a diagnosis of maltreatment and indeed, the information would be acknowledged as sufficient if the family were poor or otherwise disadvantaged. What is typically needed in such situations is not more information about the family, not another consultation, but a coming to grips with the reality that child maltreatment can take place even in nice, professional families just like the folks next door.

It is valuable to have available, within the interdisciplinary case team, professionals representing the range of disciplines from which consultations are likely to be called. For example, often the only agreement about a family violence case is that a psychiatric consultation is needed. The presence of a psychiatrist may help to inform the participants that although psychodiagnostic information can sometimes be very useful, it is not likely to provide solutions in this particular case. Similarly, while the option of leaving a difficult judgment to a court may appear to be very attractive, having a lawyer on the consultation team may help the medical personnel understand the limits of the adversary process and the capriciousness of many of its judgments. It may be that only a lawyer can convince physicians and social workers that "a recommendation to let the courts figure it out" is not a viable way of extricating oneself and one's colleagues from a difficult decisionmaking situation.

6. *Visiting clinical and social science professionals both help and hinder the case consultation process.* On the one hand, nothing matches the new fresh perspective of an informed visitor. In our experience with consultations on family violence, the occasional visiting scholar or clinician was often able to voice questions or to present corroborative information in such a way as to prompt the clinicians to think through the data differently. For example, in a case involving both spouse and child abuse, where it appeared that the juvenile court was going to force the wife to choose between a depressed husband and a severely beaten 2-year-old, a visiting sociologist noted that this forced choice might create the kind of double bind seen often in murder-suicides. This comment stimulated a reanalysis of the family relationships at the level of the family, as well as the parent-child dyad.

On the other hand, visitors can also have a negative effect on the group dynamics of clinical communication and formulation. Often, a clinician may try to play to or show off for a visitor, or bend over backwards to make a teaching point, or take time to explain courteously what is going on. His or her colleagues may seethe with impatience or suppressed laughter at such antics, and the respectful and open communication that is so essential to sound practice may be compromised.

DISCIPLINARY ROLES

The task of assembling the proposal for the training grant led, in 1978, to a discussion of the roles that each of the disciplines might play in the work of training. With the above lessons held in view, consensus was reached on the particular array of responsibilities to be met by the professionals involved in the training of the fellows. The roles of these professionals within the family violence service and training program are described below.

Social Workers

Social workers at Children's Hospital are responsible for evaluating interactions among family members, forming relationships with other hospital programs and community agencies that will be a foundation for successful external referrals for service, and making arrangements for these referrals. Social workers are available in the emergency clinic on a 24-hour basis. The family violence program had available to it three principal social workers: the chief of the social service department, the head of its community services division (who also chaired the child abuse consultation team), and the social worker for the outpatient Family Development Clinic, where family violence-related consultations take place (Newberger and McAnulty 1976).

As part of the training program, all fellows were expected to attend clinical conferences chaired by social workers and dealing with cases of family violence. The social worker chairperson or another social worker was asked to spend an hour a week debriefing each postdoctoral fellow and discussing the issues at hand. In practice, this arrangement worked for some fellows but not for others. Often the press of the social worker's clinical responsibilities reduced the debriefing hour at both ends. While some fellows felt they received enough input despite the demands on their assigned mentor's schedule, other fellows were frustrated at the lack of time to help them work through the thoughts and feelings that accompanied their exposure to family violence cases. The ratio of fellows to social workers increased over the life of the project, during which (and partly as a consequence of which) the visibility of the issues and the number of case consultation requests climbed substantially.

Nurses

A pediatric nurse practitioner whose half-time hospital appointment included assignments to the child abuse consultation unit and Family Development Clinic was available as a faculty member in the training program. Her tasks in the hospital included serving as a liaison with the nurses both in administration and on the clinical services. In this capacity, she was responsible for arranging teaching conferences, in which the fellows were invited on occasion to participate. For the fellows, she served as a strong and secure leader in her profession. Her contacts with the fellows were continuous and informal. Only rarely were formal appointments needed to sustain her input into the fellows' training. Much of her own work was in the context of the Family Development Clinic, where the one-way mirror is used in family evaluations for the dual purposes of teaching and of restricting the number of personnel in the examining room with the family. Frequently, she was the clinician observed through the mirror; at other times she participated as an observer, giving information and consultation to the fellows as the work with the family went forward.

Pediatricians

The pediatricians associated with the training program included its director, the senior pediatrician on the interdisciplinary child abuse consultation unit, and the chief of the hospital's primary care program. Each physician worked in a context with considerable clinical exposure to family violence cases. These contexts proved useful to the fellows as a source of pertinent data and case material. Each pediatrician's responsibilities included serving as administrative liaison to the clinical and administrative departments with which the fellows had contacts. The pediatricians also represented the program to clinical department chiefs; on rare occasions when conflicts involving a fellow would emerge, the pediatricians acted to troubleshoot and negotiate a solution. Among the clinicians, the pediatricians seemed most interested in making contact with behavioral and social scientists to initiate research in the family violence area.

Lawyers

The hospital's attorney played a vital and unique role in the program. The treatment of family violence inevitably involves ethical and legal dilemmas (especially regarding confidentiality and informed consent) and brings the courts into play. In this context, the attorney interpreted the legal framework for professional action and guided decisionmaking. His advice covered such situations as whether to file a child abuse report, whether and how to initiate a custody action on a child's behalf, how to file a spouse abuse petition, whether to retain a child in the hospital, and whether or how to inform a mother that her child, in State custody, had been murdered while in foster home care. The training program was fortunate to attract an attorney with a substantive interest in family violence, child custody, and interdisciplinary clinical work.

Psychologists and Psychiatrists

Opportunities were provided for fellows to conduct supervised diagnostic assessments of parents and children in the hospital's psychiatric outpatient department, and several fellows availed themselves of the chance to do psychotherapy under the aegis of the psychiatry department. Those who did become involved in providing psychotherapy participated in the pertinent weekly seminars in the psychiatry department; supervision of their clinical work was provided by two psychologists and one psychiatrist. The fellows brought to this work an orientation to theory and an energy that attracted the interest and support of the supervising professionals, all of whom reported that they learned enormously from the experience. One of the fellows, Dr. Richard Gelles, has reported at length on his clinical training experience in his paper, "Applying Research on Family Violence to Clinical Practice" (1982).

The introduction of the training program added extra work for hospital clinical staff. Moreover, as a consequence of the fellows' lack of familiarity with some of the unwritten codes of behavior in medical environments, some conflicts occurred with the professionals identified as faculty in the program. Strong feelings are inevitable in the family violence area; these feelings occasionally energized discussions about the program and interactions with the fellows in troublesome ways. For example, behavioral and social science fellows were sometimes eager to share research knowledge relevant to a case being considered in a Trauma X meeting or case conference. When the day's schedule was already very heavy, such input sometimes seemed intrusive and unhelpful to the clinical staff, who wished the fellows would save their insights for some less busy occasion.

Because misunderstandings and hurt feelings could arise under such circumstances, it proved useful to have weekly meetings with the fellows, conducted by a psychologist, to help them process their experiences as individuals and as a group. Also important were the fellows' meetings with members of the identified clinical faculty. These meetings served to cement a sense of common purpose and to place in perspective personal and professional differences. The former always healed with time; the latter came increasingly to be understood as artifacts of the differing intellectual orientations of the clinical and research disciplines. People came to know and to respect one another as individuals, and to comprehend the different ways in which they look at the world.

Chapter 7

Conclusions and Recommendations

THE INTERDISCIPLINARY TEAM APPROACH

As we have seen, child abuse/neglect management at Children's Hospital is the responsibility of an interdisciplinary team consisting of a pediatrician, attorney, psychiatric social worker, psychologist, nurse, and occasional other consultants. Such a team structure has several advantages over individual management and decisionmaking.

Advantages of Team Structure

Cases of family violence involve many specialties, each with differing and unique definitions of the situation presented. If, for example, a child enters the emergency ward with a fracture, the physician might determine whether the nature of the break indicates inflicted trauma; the social worker would interview the child's parents to evaluate their capacity to protect the child and to form a relationship that might serve as the basis for a program to prevent the injury from recurring; and the attorney might consider obtaining a restraining order to prevent removal of the child from the hospital prior to a full assessment. The primary rationale for an interdisciplinary team, then, is that many skills are required for effective task performance.

A team approach, moreover, has other functions or advantages specifically in regard to family violence. First, these problems stimulate strong emotional reactions in all of us; anger, sadness, and frustration are all too familiar. If group management exists, members can support one another and allay some of the personal distress inevitably associated with tragedy. Second, decisionmaking in this area affects family welfare and the safety and health of children. A group can bear the consequences of its decisions more easily than an individual who selects, and lives, with his or her recommendations alone.

Third, family violence cases are complex and take much time and effort to resolve. A team is able to divide the labor to facilitate the outcomes.

Team Issues

Before any team can function effectively, a number of questions must be raised and certain group issues must be recognized:

1. ***What are the norms of practice—that is, the expectations or rules that exist within the group?*** In order for a team to perform well, consensus must exist about what rules apply to the group and to individual participants. For example, all members might agree that everyone should participate in decisions concerning disposition of serious cases, but the levels of participation might differ according to the nature of the decision (whether it is primarily legal or involves medical diagnosis or social service assessment).

2. ***What roles do individuals play, and how might these roles change over time?*** After operating in an interdisciplinary setting for a period of time, participants become comfortable with the language and thought processes of each other's specialties. The pediatrician, for example, might venture a psychiatric assessment, or the social worker, a legal analysis. This crossing of disciplines is usually done with the realization that turf is being violated; apologies are given ("I don't mean to get into your area..."), statements qualified ("I"m no lawyer, but...") or immediate deference shown if the nonexpert statement is challenged by the authority. In this way, members feel sufficiently free to transcend their narrow roles but not so much as to threaten or question the capacity of their associates.

3. ***What is the status and power structure within the team?*** In a hospital setting, physicians usually have the greatest authority or influence; within teams it becomes possible—indeed, perhaps essential—to emphasize professional collegiality rather than hierarchy.

4. ***How is social cohesion maintained?*** In the interdisciplinary team, multiple divisions exist that potentially disrupt unity and harm morale. These divisions include differing professional orientations and commitments; ideological variations; diverse interpersonal styles; and sex, race, and social class distinctions. Problemsolving is sometimes limited by different

professionals viewing the same data in different ways, and an inability across disciplines to understand the concepts and tools of other specializations. In considering a particular case of family violence, a sociologist analyzing the causes of abuse probably would look to the social context in which the behavior occurs—the strains or pressures that triggered aggression. A psychologist, on the other hand, might focus on the individual perpetrator. Examining past experiences as a predictor of present action, he or she might ask, "What kind of person would act in this way?" and might attempt to construct a psychological profile from developmental history and from attitudinal/behavioral data. To a psychologist, social context is often the circumstance precipitating violence rather than its primary cause; the violence, defined as endemic, may be considered inevitable, despite the chance stimulus that induced it. The social worker may find all such considerations too abstract and be much more concerned with helping family members cope with circumstances that appear overwhelming.

SUGGESTIONS ON TEAM FUNCTIONING

Though what works at Children's Hospital may not generalize readily to other programs, the following suggestions on team functioning may prove helpful:

1. *Attempt to draft a written statement on team norms and practices.* At Children's, the team norms, for the most part, are not codified; however, a handbook written by the group outlines the task(s) each participant is to perform. The handbook attempts to standardize decisionmaking by indicating when various procedures are appropriate (e.g., taking a trauma case to court). This handbook is considered important because it educates members and lessens arbitrariness; a latent function is the reduction of conflict. We attempt to use guidelines to avoid differences of opinion and to resolve those differences that do arise.

2. *Set aside a minimum of one meeting a week to discuss team functioning and organizational/personal issues.* Too often the pressure of caseloads and clinical decisionmaking limits the group's ability to assess *group process.* Any team needs to devote time to itself and not simply to case management.

3. *Hold weekly update meetings with all team members.* At these meetings consider the medical/social/psychiatric data on

all cases seen at the hospital since the last session. This sharing permits each member to know about every case and to ask for additional information or to provide an expert opinion. The group thus maintains itself as a group and takes advantage of the interdisciplinary skills of its members.

4. *Have each member participate in case decisionmaking* according to the specific issues requiring decision. The pediatrician, for example, might examine a patient to determine whether injuries are accidental, a result of disease, or inflicted, while the lawyer might assess the medical record to determine whether the evidence is sufficient to meet a burden of proof requirement if the team urges removal of a child from biological parents and the initiation of court action.

5. *Attempt to reach a consensus* on important issues of case management—for example, whether a child abuse or neglect report should be filed with State protective services or a neglect (care and protection) petition initiated. If all participants agree with particular courses of action, then team division is less likely. If strong differences do occur, however, especially between the medical and social work perspectives, no action should be taken until efforts at resolution occur. Any remaining differences might be solved by a respected and neutral third party, such as a hospital administrator.

6. *Accept, and indeed encourage, different opinions* on case management, as they often lead to more intelligent decisions. On the other hand, keep in mind the fact that if argument becomes too intense or personal, team solidarity suffers. It is important, therefore, to consider social-emotional factors and the need for norms that allow team members to continue working with one another. Typical informal norms might include (a) maintaining equanimity in disagreement, (b) resolving disagreement through rational discussion, and (c) being supportive of one another (by showing solidarity). It is important to keep things cool and to maintain a sense of humor.

7. *Share power.* Despite the fact that in the larger society, and particularly in the hospital, a physician has greater authority and status than a nurse or social worker, the team should operate under a norm of collegiality. This norm has several components—all disciplines are equally important in decisionmaking; the quality and logic of a suggestion is more important than the status of the person offering it; and no person or role representative has the right to veto a recom-

mendation acceptable to other group members. This norm increases individual assertiveness and the feeling that one may operate without fear of sanction—all of which leads to group morale, commitment, and cohesion. Task effectiveness is likewise enhanced. No single discipline has greater knowledge or insight into family violence management than the others; thus, no single discipline should be accorded weight merely because of what it is, as opposed to what it contributes.

One of the ways to share power is to rotate the conference chairperson rather than having the same discussion leader at each meeting. This device, of course, might merely disguise the true power structure; however, if used properly, it can enhance team collegiality. It is also valuable if a physician takes the responsibility for acknowledging the importance of the nursing and social work perspectives and approaches rather than leaving it to members of those disciplines to assert their own value.

INSTITUTIONAL ISSUES AND TEAM FUNCTIONING

In a medical center with a biomedical orientation and a deemphasis on child development, trauma teams may lack social and economic support. Thus, the team should fall within the jurisdiction of a hospital administrator who can act as its advocate. The team should also receive financial support from the institution rather than relying on grant monies or private contributions. Without financial backing, the professionals will not remain committed to the difficult work of case management; moreover, task quality will suffer because of a lack of secretaries, computers, or other facilitators.

Within the hospital setting, teams exhibit either a consultative or directive mode of operation. In the *consultative mode*, members consult with other professionals who actually provide services to families. The team pediatrician, for example, may conduct a medical examination to determine if fractures resemble inflicted injuries, but the house officer, after receiving input, maintains case control and makes decisions about abuse/neglect reporting and discharge. In the *directive mode*, the staff of the various hospital divisions transfers management responsibility to the abuse team, which provides services and assessment while also determining case disposition.

At Children's Hospital, though the formal procedure is consultative, actual team functioning may become directive. Certain staff members dislike child abuse cases and willingly surrender responsibility to the "experts." Others have a strong sense of turf and clearly indicate their desire for the trauma team to play a subordinate role. With the most serious cases of abuse/neglect, however, especially those that involve court petitions, the team becomes more directive even with those professionals who would otherwise wish for independence. If the lawyer, for example, believes that psychiatric evaluation of the parents would assist his/her presentation of a court petition, staff psychiatrists may be pressured to defer even when they personally see no clinical need for the evaluation.

Because of the confusion between consultative and directive orientations, questions often arise over which decision should be made by the team and which ones should be made by other hospital staff. Questions also arise as to how authority and case control should be divided between staff and team. Team members expend much effort to avoid offending division staff and attempt, through sensitive persuasion, to get division staff to do what the team recommends.

Unfortunately, many hospital staffers do not like the trauma team or trauma cases. The team is seen as interfering or disruptive, e.g., by considering social issues while physicians want merely to mend the broken bone and send the patient home. Abuse cases are complex, unpleasant, and demanding.

Group cohesion within the team is sometimes increased by this attitude of being outsiders within the hospital community. Team members begin to believe that only they are concerned about the welfare of the total child and that legitimate needs of children and families are being slighted. Members may also fear that team expertise is going unrecognized or that lack of consultations will threaten team survival. Too much of a we/they orientation, however, only isolates the team from other colleagues and creates member alienation and burnout.

In our experience, family violence training program directors can contribute significantly to improved relationships between the trauma team and others by inviting staff to seminars, and by finding behavioral and social scientists to teach on the unit. Such efforts give the trauma team credibility as a force that can attract talented professionals or preprofessionals who wish to learn from its members.

It is also important for the team members to maintain links to their own discipline—the nurse to nurses, the social worker to social workers. When problems arise within a particular discipline, the team professional in that discipline can attempt to resolve intergroup conflicts.

GUIDING PRINCIPLES

From our early experiences in developing a family violence service program, we established a set of principles to guide our Family Violence Training Program. Each of these principles was designed to address concrete problems in case management, to facilitate interdisciplinary cooperation, and to bring the relevant conceptual and empirical tools into effective operation in a hospital setting. These principles have withstood the test of time, and we recommend them to individuals in other settings who wish to address the problems raised by a desire to respond more effectively to family violence.

1. *Develop broader and more adequate conceptual perspectives for medical and other health practice.* Problems in clinical practice make it clear that more adequate intellectual tools are greatly needed in the family violence area. Health personnel need to be more aware of the complexity and many dimensions of the family violence problem, including the policy and functional implications of the diagnostic labels that they may apply in the course of such practice. Careful attention needs to be given by clinicians to the adequacy (or inadequacy) of concepts such as child abuse and child neglect as a basis for practice. Clinicians should be given an opportunity to consider whether emphasis in the family violence area should be directed solely at the specific illness of the patient or expanded to include the evaluation of the patient's needs within the family and social setting (Newberger et al. 1976).

2. *Promote greater cooperation among health and mental health professionals rendering clinical services.* Problems of family violence are interstitial in the sense that several different fields need to work together to provide effective treatment and service. In a case of child abuse or interspousal violence, a physician may treat the physical injury while a social worker obtains the family history and an attorney advises on the legal aspects. Unfortunately, because of specialized and narrow professional training, persons of different disciplines may not relate effectively to each other and to human needs in cases of family violence. Another factor to be considered is

that the health workers who often seem best able to understand the familial and social contexts—psychologists, social workers, nurses—often have minimal access to the physicians and attorneys who make major decisions. Thus, means should be sought to lessen or eliminate such barriers to effective provision of health services.

3. *Increase sensitivity of health care providers to cultural, social, ethnic, and economic factors that have important implications for effective service.* Hospital clientele often come from different ethnic, socioeconomic, and cultural groups than the providers of health care. Such differences can make it difficult for health care personnel to develop rapport with persons needing assistance in the family violence area, or to understand and treat effectively the individual and social problems presented to them. Poor and/or minority persons are more readily labeled and stigmatized as child abusers and wife beaters and their cases managed coercively (for example, with removal of the child from the family or notification of police) than are patients who are more affluent or influential (Newberger and Bourne 1978; Bourne and Newberger 1977).

4. *Promote more productive communication and collaboration among professionals in clinical practice and behavioral and social science research.* Ways need to be found to relate family violence research more effectively to clinical needs, and to use exposure to clinical practice as a means of sensitizing researchers to clinical concerns. Improved communication between the worlds of research and practice can assist greatly in developing improved conceptual and theoretical frameworks for practice, and in encouraging interdisciplinary research efforts and findings of practical value to clinical practice.

What steps can be taken to accomplish those goals in other settings, particularly settings that cannot offer postdoctoral fellowships to clinicians and academicians interested in family violence? Clearly, the financial constraints facing most medical institutions today impose limitations on the creation of training programs; nevertheless, several elements of the Children's Hospital program, particularly the inservice training and seminar, could be adapted to reduce their cost.

CLINICAL TRAINING IN AREAS OF FAMILY VIOLENCE

Obviously, not all medical institutions have a Trauma X Team or Family Development Clinic to provide trainees with direct clinical experience in the area of child maltreatment. Nevertheless, most pediatric or family practice hospitals have services devoted to the treatment of injuries in children and are charged with the responsibility of recognizing and reporting child maltreatment. Such services can benefit from cooperation in postdoctoral training efforts designed to respond to the demands placed on medical institutions by laws relating to child abuse and neglect. Moreover, many such institutions have departments of psychiatry, and these departments can be a source of experienced personnel for supervising the clinical experience of trainees. In our own Family Violence Training Program at Children's Hospital, efforts to enlist the Department of Psychiatry to supervise fellows met with varying degrees of success. Appointing a psychologist from the Judge Baker Guidance Clinic as a program faculty member increased our ability to provide clinical supervision.

Whatever modifications must be made to accommodate the realities of other settings, five additional principles derived from our own experience with clinical training seem well worth considering. Our own efforts to establish a program guided by these principles have permeated the pages of this monograph. We hope that individuals in other settings will see the value of these principles and find ways to develop programs designed to follow them.

1. *Clinicians can benefit enormously from participation in an intellectual forum, from opportunities to leave the hurly burly of the clinical environment and deal with each other in a personal way concerning issues of knowledge.* The clinical practice setting is often emotionally charged and fraught with conflicts across professional boundaries. Clinical data are highly complex, and dealing with these cases can be frustrating, even exhausting. The opportunity for a more intellectual perusal of issues related to clinical practice in an atmosphere that eases communication can provide a useful respite.

2. *Programs should find a way to provide clinicians with research information that is directly relevant and helpful to their practice.* Even bright, sensitive, and caring clinicians can fall prey to such myths and stereotypes as the notion that if a home is neat and clean there is little likelihood of violence. During his year as fellow, Richard Gelles repeatedly countered such clinical assumptions and beliefs with research data. His familiarity with research evidence finally persuaded clinicians that abuse is not just a parent-child phenomenon but can char-

acterize a range of family interactions. With his input, clinicians learned to worry about how mother got her black eye and not just about how the child became bruised. Clinicians often have had very inadequate training in the area of family violence and can benefit greatly from exposure to knowledgeable researchers in the field.

3. *Priority should be given to the perspectives and expertise of individuals in nursing and social services.* Professions with large proportions of women need to be empowered in medical environments. Often male-dominated professions have the most power and least perspective on problems such as interspousal violence. Such male-dominated professions tend to be symptom- and procedure-bound. By contrast, nurses and social workers tend to be more thoughtful, sensitive, and understanding; they attend to relationships. It is important to create ways for all professions, not just the traditionally female professions, to deal with subjective issues and handle feelings and values.

4. *Linkages should be set up between the health-providing agencies and academic institutions.* While adding such linkages may demand considerable time and effort on the part of individuals in both settings, the potential for payoff is also considerable in the form of professional enrichment and improved management of family violence. Hospitals can provide congenial settings in which academics can teach and learn from practitioners. Researchers and practitioners typically share a concern with promoting human welfare. Learning to speak each other's language and cooperate in identifying and dealing with the human problems that pervade the medical setting is not impossible.

5. *It is important to promote positive relationships between health- and social service-providing agencies.* Seminars and interdisciplinary case conferences are useful means for bringing together people from different settings and stimulating professional collaboration. Such opportunities for exchange and cooperation among professionals, whose responsibilities may differ greatly on a superficial and concrete level but converge when human welfare is considered on a more general level, can only enhance the effort to reduce the impact of family violence.

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